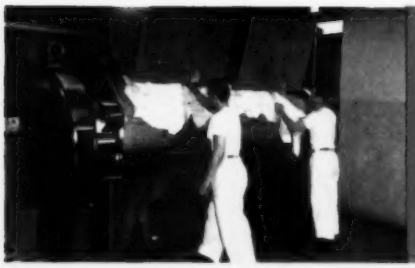
December, 1957

Canadian Hospital

- *Of Eternal Merit*
- *The Art of Making Do*
- *Cholesterol in the Diet*
- *O.H.A., Year of Challenge*
- *Alberta Hospital Convention*
- *Hospital and Nursing Conference*

Canadian Hospital Association



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The Canadian Hospital Association is the federation of hospital associations in Canada and the Canadian Medical Association in co-operation with the federal and provincial governments and voluntary non-profit organizations in the health field.

Canadian Hospital

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Contents

December, 1957, Volume 34, No. 12

(For Subscription Rates see page 101)

Business Manager: Charles A. Edwards
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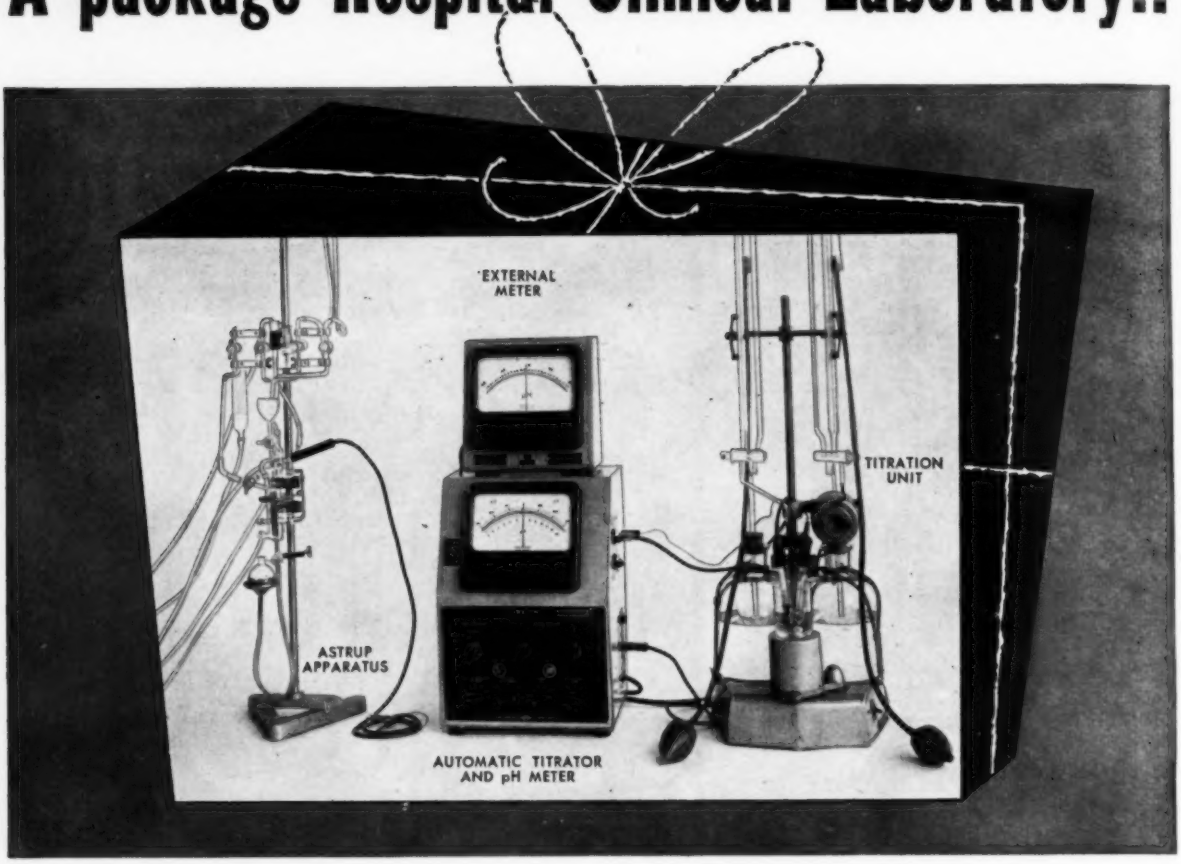
A package Hospital Clinical Laboratory..



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Notes About People

Appointments to the Ontario Hospital Commission

David W. Ogilvie, formerly director of Ontario's Blue Cross Plan for hospital care has assumed a new position with the Ontario Hospital Services Commission. He will serve in three capacities: as a commissioner, as secretary of the Commission, and as director of its hospital insurance program.

Mr. Ogilvie has been associated with the Ontario Hospital Association's Blue Cross Plan since July 1947. He joined the organization as deputy director of Blue Cross and was appointed director on January 1st, 1950.

Since allying himself with the Blue Cross movement, Mr. Ogilvie has held many important positions in both the national and international Blue Cross fields. As chairman of the Canadian Council of Blue Cross Plans in 1950, he was given the title of Honorary Chief Peace of Mind by Alberta's famous Sarcee Indian tribe. He has been commissioner for Canada on the Blue Cross Commission of the American Hospital Association. He is also a member of the Commission's Inter-Plan Transfer Board. Late in 1956, when the Canadian Council of Blue Cross Plans officially became an incorporated organization, Mr. Ogilvie was appointed the council's vice-president and executive officer.

In view of his broad experience in the field of prepaid health care, Mr. Ogilvie has, for the past four years, provided active assistance to Ontario government officials in laying the foundations of the new hospital care insurance plan which becomes operative January 1st, 1959.

D. W. Ogilvie

Also appointed to the Commission was Dr. R. W. Ian Urquhart, a native of Saskatchewan. Dr. Urquhart most recently has held the post of director of medical service with the Hydro-Electric Power Commission of Ontario, which he accepted in 1947. He has been closely associated with the Canadian Red Cross and is Honorary treasurer of the Ontario Medical Association.

Alister MacArthur, the third new appointee to the Commission, has been president of the Ontario Provincial Federation of Labour from 1946 to 1956, and during the years from '41 to '45 he was executive board member of the Toronto and District Trades Council. In 1951 he was a workers' delegate to the International Labour Organization held in Geneva, Switzerland.

For the past few years Mr. MacArthur has been a member of the Ontario Hydro Advisory Council, and at the present time serves as general organizer in the Office Employees' International Union AFL-CIO.

Dr. R. J. Collins Retires

Dr. R. J. Collins has retired as superintendent of the Saint John Tuberculosis Hospital at East Saint John, N.B., where he had served for 28 years.

Dr. Collins received his medical training in the United States and in England, Scotland, and France. He came to Canada in 1917, and has held the post of assistant superintendent at the Nova Scotia Sanatorium at Kentville, N.S., from where he went to the Balfour Sanatorium in British Columbia. Dr. Collins returned to the Maritimes as superintendent of the Jordan Memorial Sanatorium, The Glades, N.B., in 1923. In 1930 he took over at the Saint John Tuberculosis Hospital. Dr. Collins is a fellow of the Royal College of Physicians and Surgeons in Canada, and has been a member of the council of the College as well as its vice-president. Certified in clinical medicine, he became a fellow of the American College of Physicians and has served as president of the Canadian Tuberculosis Association as well. He is succeeded by Dr. Lachlan Macpherson, formerly assistant superintendent there.

Staff Changes at Perth

Several staff changes have taken place at the Hotel Dieu of Saint Joseph Hospital, Perth, N.B. Sister B. Legere, who has been administrator of the hospital for five years, has been transferred to St. Basile. Sister L. Godin, formerly director of nursing, has taken up the administrative duties.

Sister M. Hammond has become business manager and Sister A. Toussaint, supervisor of the medical floor and paediatrics. Sister L. Grant is now in charge of the x-ray department.

A.C.H.A. Nominees

Soeur Marie-du-Christ-Roi

J. R. Bryan

Accepted into nomineeship at the October convocation of the American College of Hospital Administrators was Jackson R. Bryan, superintendent at the Welland County General Hospital, Welland, Ont. Soeur Marie-du-Christ-Roi of Hôtel-Dieu de Montmagny, Montmagny, P.Q. also became a nominee.

(continued on page 18)

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People

(continued from page 12)

Dr. D. G. Cameron Accepts Montreal Medical Post

Dr. Douglas G. Cameron, a native of Swift Current, Sask., has been appointed professor of medicine at McGill University and physician-in-chief of the Montreal General Hospital. This position also includes the post of director of the University Medical Clinic.

Dr. Cameron holds science degrees from the University of Saskatchewan, and Oxford (where he studied as a Rhodes scholar), and has been connected with the Montreal General Hospital since 1946. He is a member of the Royal College of Physicians and Surgeons (London) and a fellow of the Royal College of Physicians and Surgeons of Canada, a fellow of the American College of Physicians, and a fellow of the International Society of Haematology.

New Administrator at North Bay

Oliver Whitcroft, a native of St. Thomas, Ont., has taken up the duties of business administrator for the Ontario Hospital, North Bay, Ont. Mr. Whitcroft has been with the Ontario Hospital at Langstaffe, Ont., for the past two years, and has had previous experience as assistant bursar of the Ontario Hospitals in both Kingston, Ont., and St. Thomas, Ont.

Appointed Hospital Council Co-ordinator

Sidney Parsons has assumed the duties of co-ordinator for the North Central Regional Council of Hospitals, in Prince Albert, Sask. As co-ordinator, Mr. Parsons will organize and direct the consulting services which the council provides to the hospitals in that area. A graduate of the University of Toronto, in both arts and social work, he also holds a diploma in hospital administration from the U. of T.'s School of Hygiene. Prior to his new appointment, Mr. Parsons was with the Division of Hospital Administration and Standards, Department of Public Health, Saskatchewan.

Priscilla Campbell Honoured

An oil painting of Priscilla Campbell, former administrator of the Chatham Public General Hospital, was given to the nurses' residence which has been named in Miss Campbell's honour. The portrait, painted by Clare Bice, curator of the London Art Gallery, was presented to the hospital board by Dr. Laird Story of Blenheim, representing the medical staff of the hospital. It was the hospital staff's way of thanking Miss Campbell who retired in April 1957 after 35 years of service.

F. H. Silversides Resigns

Franklin H. Silversides, administrator of the Halifax Children's Hospital, Halifax, N.S., for the past four years, has resigned his position to serve as a hospital management consultant for the Department of Health and Welfare in Ottawa.

A native of Winnipeg, Mr. Silversides graduated from the University of Manitoba's faculty of pharmacy. After taking a postgraduate course in hospital administration at the University of Toronto, he became superintendent of the Children's Hospital in Winnipeg, a post he resigned to go to Halifax.

Dr. Scott Heads Royal College

Dr. John W. Scott, dean of medicine at the University of Alberta is the new president of the Royal College of Physicians and Surgeons

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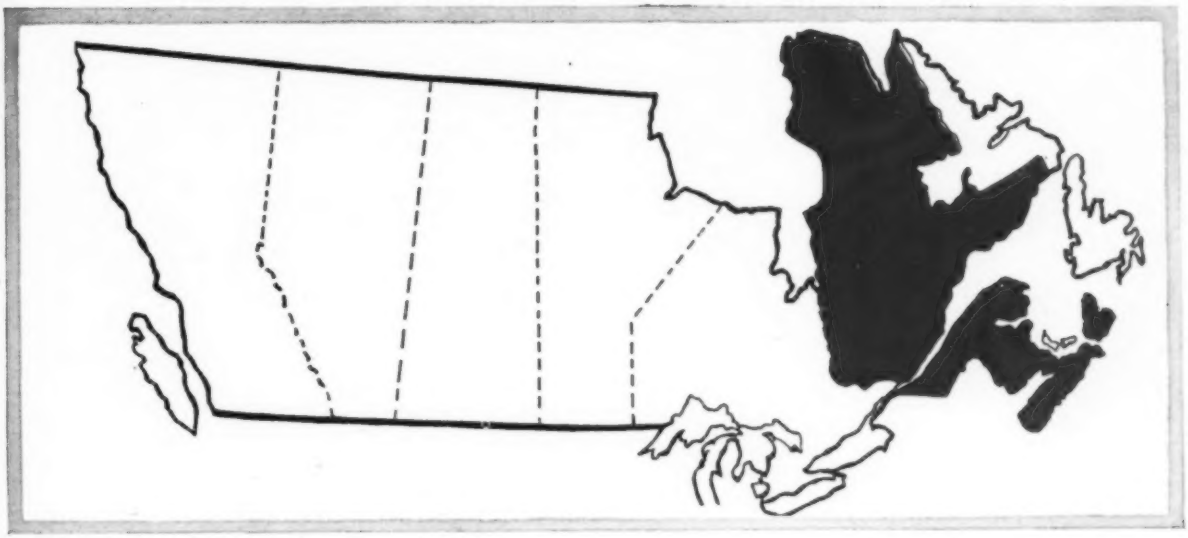

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People
(concluded from page 18)

of Canada. Dr. Scott, a professor of medicine since 1944 at the Alberta university, has been a governor of the Royal College, chairman of the western division of the medical committee for the National Research Council of Canada, and 2nd vice-president of the Association of Canadian Medical Colleges.

Administrator Honoured by Staff

Fred Whittaker, administrator of Western Memorial Hospital, Cornerbrook, Nfld., was presented with a mounted clock and barometer set, by hospital union members. The gift was a token of the employees' appreciation of the administrator's efforts on their behalf. The employees' spokesman asked Mr. Whittaker to accept the gift as a token of their goodwill because, he said, "There have been so many changes for the good and welfare of the hospital personnel since you took over, that the empoyees wanted to show their appreciation."

New Radiologist Appointed

Dr. David Chapman has been appointed radiologist at the Nora-Frances Henderson Hospital, Hamilton, Ont. Dr. Chapman, a graduate of London University, England, earned his radiology diploma at Guy's Hospital, London. After coming to Canada in 1952, he secured specialist certification in diagnostic radiology at Kingston, Ont., and has been chief of the radiology service at the D.V.A. Westminster Hospital in London, Ontario, since 1955.

Medical Specialists at Brockville General

Two new physicians, Dr. Ronald Brannen, radiologist, and Dr. William J. Wyatt, pathologist, have joined the staff of Brockville General Hospital. Dr. Brannen comes from Nova Scotia and has degrees from four different universities in Canada.

Dr. Wyatt, a graduate of McGill University, will serve as pathologist for both the Brockville General and St. Vincent de Paul Hospital in Brockville. He has most recently been with the Hotel Dieu in Cornwall, Ont.

• Dr. Fred Snedden has been appointed superintendent of the Ontario Hospital at Brockville, Ont. Dr. Charles E. Hanna, for 13 years medical supervisor at the Brockville Ontario Hospital, retired last September.

• Dr. J. M. Downing has been appointed to be in charge of the radiology department of Prince County Hospital, Summerside, P.E.I.

• Dr. Anthony J. M. Grifiths has left the University of Alberta Hospital, Edmonton, Alta., to be full-time radiologist at St. Martha's Hospital, Antigonish, N.S.

• K. Marshall has taken over the duties of director of nurses, succeeding M. Jameson, at Jeffery Hale's Hospital, Quebec City, P.Q.

• Constance Lax has been made director of nursing at the Chatham General Hospital, Chatham, Ont. Miss Lax joined the Chatham hospital's staff ten months ago. She succeeds Barbara Beattie.

• Ferne Trout has assumed the duties of nursing supervisor at the Penticton Hospital, Penticton, B.C. Prior to this appointment, Miss Trout was assistant director of nurses at the Royal Inland Hospital, Kamloops, B.C.

• Dorothy MacDougall has succeeded Mrs. Roy Goodfellow as superintendent of the Pontiac Community Hospital, Shawville, P.Q.

W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

Bus Stop

WHEN a new hospital is to be built, choosing a suitable site is one of the first problems encountered and, in making a choice, an important factor for consideration is accessibility to transportation lines. It is interesting to note that in *Hospital Organization and Management* (third edition) the late Dr. MacEachern lists eight considerations which have to be weighed carefully in this connection and accessibility to transportation tops the list. A location may meet all other requirements but if those who are to use the hospital and those who are to provide its services cannot reach it easily, then the site is not a good one.

Easy transportation to and from work is a major factor in attracting and holding personnel. Today there is not the high percentage of hospital workers living in residence that there was a few years ago. The many who work on broken shifts, who come and go at odd hours, require a bus or street car, not just at rush hours, but as a service that is regular and frequent. It may be recalled here that when public transportation broke down for several days in one large Canadian city, numerous organizations rushed in to offer hospitals the use of private automobiles. The public urgently insisted that hospital service must not be handicapped by lack of transportation for staff. Neither a new hospital in the suburbs nor an older one anywhere can function adequately if its personnel cannot come and go readily and inexpensively.

Good roads leading to the institution are necessary for the delivery of goods and will satisfy the needs of most patients. However, many out-patients and visitors will want to reach the hospital by bus or street car; and lacking these, they may be, for hospital purposes, quite immobilized and certainly unhappy.

The time to make certain that there will be good transportation facilities is before the site is purchased. Negotiations should be entered into with transportation facilities to find out just what kind of service is or can be made available. Arrangements should be definite. If the problem of transportation is left until the doors are about to open, it may well be that preconceived ideas or half promises will turn out to be will o' the wisps.

On Rising Hospital Costs

HOSPITAL charges have increased markedly since World War II and are still rising. Donald C. Cordes, administrator, Iowa Methodist Hospital, Des Moines, Iowa, in addressing the sixth Manitoba Hospital and Nursing Conference, stated that in the past decade hospital costs in the United States have increased some 223 per cent and that the increase in 1956 over 1955 was nine per cent. Many reasons have been advanced to account for this almost spectacular rise, but, as the speaker pointed out, the primary one is the fundamental change in the treatment of the patient.

With rising costs there has been a remarkable shortening in the average stay of patients. What is sometimes forgotten is that reduced stay calls for intensified care. This requires much new equipment, more building space, and a larger administrative team. Thus in speaking of higher hospital costs, it is necessary to look at the whole picture. Part of the story is the result of changing economic conditions, such as the shortening of the work week and higher wage scales, in keeping with the general trend in the community. But equally important is the fact that hospitals are employing many more categories of skilled personnel than they were a decade ago. These appointments have been made necessary because of advances in medical science and the resulting greater demands being made on hospitals today.

On the other hand, while cost of hospitalization per day has increased enormously, the cost per illness in hospital, particularly in acute cases, has not shown a corresponding increase. In some cases it is no higher than it was three decades ago. For instance, the cost to a patient with appendicitis who spends six days in hospital, at $14.00 per day, compares not unfavourably with that paid by a similar case in the twenties who spent up to 15 days in hospital at, say, $5.00 per day. Hence the cost per illness is a much better yardstick to use than the cost per day.

Christmas Greetings

Christmas is essentially a family day; when the thoughts, at least, turn homeward even if the footsteps cannot follow.

Individual peculiarities and differences are forgotten in the warmth of affection permeating the family circle. Thus is perpetuated through the ages the theme of that first Christmas —"Peace on Earth, Goodwill towards men".

My fellow officers and directors join me in extending Christmas greetings to the entire hospital family.

Voeux de Noël

Le Noel est essentiellement une fête de famille; une fête où les pensées et les coeurs se tournent vers la maison paternelle; où les plus heureux en prennent effectivement le chemin.

Jour de joies, au sein des familles et des sociétés, où tout ce qui sépare s'estompe pour laisser place à tout ce qui unit. Ainsi chaque nouveau Noel ramène au sens véritable du cantique des anges: "Paix sur terre aux hommes de bonne volonté".

C'est dans cette atmosphère de fraternelle intimité que les membres de mon exécutif et les directeurs de notre Association se joignent à moi pour souhaiter un Joyeux Noel selon l'esprit du Christ à la grande famille hospitalière.

D. F. W. Porter, M.D.
President
Canadian Hospital
Association

Of Eternal Merit

Msgr. J. P. Sullivan,
Kingston, Ont.

THE modern hospital is a triumph of our Christian civilization. The Incarnation of the Son of God or the coming of Christ was the pivotal point of all history not only in regard to man's relations with God, but also in regard to man's relations with man. With the beginning of this era a new force entered the world and permeated every department of human endeavour. Regarding one's fellow men there was a new motivation, for after proclaiming the corporal works of mercy, feeding the hungry, clothing the naked, visiting the sick and the rest, Christ said "inasmuch as ye have done it unto one of the least of these my brethren, ye have done it unto me". Hospitalization became a virtue, the practice of medicine one of those works, and research another opportunity to proclaim the goodness of God. Slowly the accumulated science of medicine uncovered long-hidden secrets, captured long-dormant forces and gave to man the healing elements of nature which are the remedies designed by God for the alleviation of human ills. Thus has God been honoured in your sphere of activity by scientists who considered their efforts to prolong human life as sincere co-operation with the eternal Source of Life, and who considered their efforts to lessen man's suffering as an anticipation of the Beatific Vision.

That is the way it must be if your goals are to be reached. There must be religious motivation. Human acts derive their efficacy from the impulse to action that transmits thinking into doing and the nobler the motive the more meritorious the endeavour and the more dynamic and sympathetic the service. Human motives have some great accomplishments but, with the rank and file of humanity, there is no motivation comparable to that of religion. The hospital must be a centre of applied christianity based on the origin and destiny of man; and all this applies not only to doctors and nurses who are in close contact with the patients and who achieve the results but, also, to board members and administrators.

Recall for a moment the parable of the Good Samaritan which Christ used to impress upon a young man the identity of his neighbour whom he was to love as himself. A certain man went down from Jerusalem to Jericho and fell victim to highway robbers. He was beaten, abandoned, and left half dead. Two men who had a real obligation to do something came on the scene, a priest and levite, but they did nothing. Then a Samaritan riding along on business, spotted the dying man, rushed to him, and administered first aid. He provided ambulance service, brought him to a hostel, looked after the financial arrangements for him and left instructions that he was to get the best of care. The question then was who of these three was the neighbour; the answer was "he who showed mercy" and the admonition "go and do thou in like manner". These words spoken for all time bring you into the picture and I am sure you easily recognize yourself. Of course things have changed and the technique of the Samaritan is obsolete. But note that his charity did satisfy the basic emotional needs of the victim and in your generous enthusiasm that is what you must do. Love and security summarize the requirements of all patients from the premature nursery to the geriatric ward.

In a way it is strange that the word "hospital" has survived modern times because in derivation it carries us back to a hospice or hostel where some kind of charity was dispensed to the poor. Now as far as these institutions are concerned, there are comparatively

(continued on page 76)

From an address presented at the annual meeting of Region No. 9 of the Ontario Hospital Association, held in Kingston in September. The author is Rector of St. Mary's Roman Catholic Cathedral in Kingston.

Women's Auxiliary Entertains

Aged Out-patients

EVER since the late Jean I. Gunn, O.B.E., LL.D., became head of the training school for nurses at the Toronto General Hospital in 1913, there has been a Christmas tree in the out-patients' department. It began as a special party arranged for the children of out-patients by Miss Gunn and the nursing staff, with assistance from the Social Service Association, and from the late Mrs. R. B. Hamilton, who purchased gifts of clothing from funds collected by her for that purpose. Since her death, this work is continued in her memory by a former associate. Many association members took large, red, net stockings to fill with new clothing as well as with candies and toys, and assisted in transportation of the small guests. There was a Punch and Judy show, ice cream and cake, Christmas carols sung by the nurses' choir, and a Santa Claus, complete with jingle bells, running down the broad staircase to deliver the gifts in person.

The Christmas tree and party are there this year too, but for a different age group. This change is indicative of one of the great problems facing the social service worker today—the problem of the old people. Not only has medical science prolonged life, but industry is retiring men and women from active work at an earlier age. Many who retired during the past ten years were unable to keep up their savings during the preceding ten—the depression years—and old-age pensions alone are not sufficient for them to live on. Even where families do wish to take ageing parents or relatives into their homes, the housing shortage and high cost of living make it a struggle. These new factors are aggravating a situation that was always difficult.

So, in the mid-forties it was decided that the Christmas party should be given for older people instead of for children. The nurses still act as hostesses, passing the refreshments, which now include tea and sandwiches. Their choir, directed by Mary Macfarland, superintendent of nursing at the hospital will sing traditional Christmas carols again this year. Although social service became a department of the hospital in 1954, the voluntary workers, now called the Women's Auxiliary, still sponsor the Christmas party.

More suitable entertainment has replaced the Punch and Judy show, but Santa Claus still hands out the gifts. Each patient, brought to the party by taxi, if necessary, receives through the Christmas fund not a filled stocking, but a crisp $5 bill to spend as he most wishes.

The Art of Making-do

Lawrence E. Ranta, M.D.,D.P.H.,
Assistant Director (Medical),
Vancouver General Hospital,
Vancouver, B.C.

ONE of my younger children saw my scribbled notes for these paragraphs. Laboriously he read the title: "The Art of Making Dough". In the language of dollars rather than doughnuts, he struck near the nubbin of my intent. Nevertheless, something of a culinary sense was also intended. Three courses of ordinary fare were prepared, like the porridge of our childhood, to stick to the ribs of anyone interested in the welfare of the long-term ill.

The Art of Living-it-up

The current issue of practically any medical journal will carry some article dealing with rehabilitation. This is a lively issue everywhere. Some areas are far advanced. Others are just coming upon it with the same wonderment as the savage in some isolated jungle who comes upon a shiny new shovel that has dropped from an airplane. He has never seen a manufactured object before.

Does he hang it in his hut and admire it as an ornament? Does he worship it as a symbol of divine blessing? Does he club his enemies with it? Or does he discover its value as a tool and use it for the advantage of his village?

We, here, are not quite like the native. We know what the tool of rehabilitation is for. We can quote its values. We know how it can "make dough". We can document how much has been earned by persons restored to useful activities. How the income tax paid by them in their first year after restoration has paid off a sizable share of the costs of their treatment. We can claim that restorative treatment will move x numbers of hospital patients into nursing homes or from nursing homes to homes.

At this stage of our development, it is probably proper that the economic outlook should guide our thinking. But this attitude should not be allowed to cloud our thinking regarding the real objectives. It threatens to do so.

Restorative medicine is the application to the patient of the art of making-do. We must make-do with the resources of the individual and develop them to the greatest benefit of the patient. Yet we must remember that the patient's resources do not begin and end with his locomotion and his bodily functions.

For example, what a pity that a trained economist suffered a stroke! How fortunate that he survived and learned to walk again! What a pity that two years had passed before a speech therapist was engaged to teach him to talk again! How fortunate that he learned, although it took many months! And what does he say now? "The thing I missed most was not being able to speak with my friends. Speaking and listening has been my life. Without speech, I was half dead."

Locomotion was not the total key to his restoration. Fortunately, by making-do with the resources he had, his mind was given the wings of speech.

And what of the little old lady of some 80 years, badly crippled with arthritis, who had vegetated in a nursing home bed for months. She was in misery. She was miserable. She had a dark grey cloud around her. After diligent effort, a craft worker devised a yarn-holder for her and persuaded her to start knitting. She did it painfully at first, later more efficiently. She knitted afghan squares, by the dozens and dozens. She became a regular factory of afghan squares. Though she remained in her bed in the nursing home, she was cheerful. *There was sunlight around her.* Making-do with what little muscle movement she had—making-do with the vestiges of a pride in knitting—was the key to a new world for her. That world of creation, though restricted, was an important conquest in restorative medicine.

The point to be made is simple and obvious. Let us not lose sight of the patient while we restore him. Restoration is more than putting a body back on the road. Restoration is, very often, the re-creation of an individual to permit him "to live it up" according to his abilities. The new shovel we found in our jungle is a versatile tool. It can be used to mix cement, dig a trench, and plant delphiniums too!

It would seem redundant for me to point out the values of the person who has been restored to useful life. But perhaps we are so often faced with the economic and humanitarian arguments that it would be worth while to recall the intangible assets. Contrary to the misunderstanding of some employers, he who can find a place for a handicapped person is fortunate. Do we not hire people for what they have in their heads or the craft of their hands? The well-adjusted — the restored — the re-created — handicapped person brings his employer a bonus. He brings a depth of spirit far greater than that of the usual employee. Fired in the kiln of a particular type of deep personal experience, his is no ordinary clay. It makes of him an exceptional employee. This bonus-value is not measurable in dollars and cents. It surpasses the values of the market place. It often shows that the rehabilitated person, in "making-do" with what facilities he has, will outdo the individual who has never recognized a handicap and who uses his "Cadillac" resources like a Model T.

The Art of Boring-from-within

Various opinions have been expressed about the most important problems to overcome before we and our neighbours can best profit from restorative medicine. Some have claimed our greatest need is personnel, others say money, still others say facilities. What else is there besides people, money to pay for them, and a place for them to work? It would be boldness, indeed, to place all these as secondary, but courage comes from a remembered comment by someone who said that man is a different breed, for, unlike horses, all men are created equal. This gives a clue to the difficulties that restorative medicine must face regardless of personnel, money and facilities. Because we are created equal, we are very likely to overdevelop a proprietorship in our own opinion, in our own family, in our own work, in our own institution. In time, this overdevelopment of proprietorship in our own institution will tend to make us colour our decisions in the interests of our

From an address to the Annual Meeting of the Gorge Road Hospital, March 20, 1957.

institution, rather than in the interests of the patients it should serve.

This is no idle prospect, no idle danger. There are many institutions today whose managements sincerely believe their institutions are doing their jobs well, but which are hampered by failure to recognize that their policies and decisions often interfere with the best interests of the people they were set up to serve.

During the days when restorative medicine was a rarely practised art, insularity of institutions was probably not very damaging, but from now on (to paraphrase John Donne) "no institution is an isle, entire unto itself . . ."

The practices of restoration depend upon flexibility in the application of services to the patient according to the needs of the patient. This demands proper timing as much as proper services. The patient must be able to move from one service to another, from one class of institution to another, without entanglements in individual institutional idiosyncracies.

The integration of all restorative services in any community is difficult to achieve. The more parts there are to bring together, the more difficult it is. Even when it is achieved, only constant vigilance prevents deterioration of this attitude of dependence.

Friendly social relations between boards of such dependent institutions are not enough. It is much moré important that the staff workers themselves have the attitude that they participate in a program larger than the institutions they serve. This requires continuous staff education. Upon its success rests the success of the restorative program. Only in this way can the community have a guarantee that the people, the money, and the facilities they provide will do the job they are intended to do.

This takes "boring-from-within". Frequently efforts must be made to undermine the natural development of insularity in the staffs of each co-operating institution. This takes effort to achieve, if it is to be done without threatening the pride that the good worker must have in his work. But the effort will be rewarding to every patient and, indeed, to every worker and every citizen. To the community it represents the art of of "making-dough", for only in this way can we be sure that money, people and facilities are being used in the most effective manner.

The Art of Robbing Peter

As everyone recognizes, we are faced with a shortage of personnel in restorative medicine, a shortage of doctors and nurses trained in physical medicine, of physiotherapists, occupational therapists, psychologists, speech and hearing therapists, social workers, resettlement counsellors and the like.

Some of us believe that our difficulties in personnel could be completely, effectively and permanently solved by increasing training facilities.

It is true that this is the basis for the solution of our problems.

L. E. Ranta

Nevertheless, a responsibility rests upon the institutions that engage specialized personnel, and no small responsibility rests upon the individuals engaged and upon the associations to which they belong.

To the institution belongs the responsibility of job-tailoring. Some personnel practices require renovation if we are to be assured that workers in the health field will be permitted to put forth their best efforts.

The institution should not consider its task wholely done simply by preparation of a job description. The problem of effective staff utilization really begins only when the individual has been hired. At this time an employee analysis is essential in order to adjust the work to the talents of the new employee. The "custom tailoring" of the job to the individual is much more likely to yield better results than assuming that the "ready-to-wear" job is most productive. Robbing Peter under these circumstances may be in the best interests of the art of making-do and "making dough".

To have a social worker spend most of her time telephoning taxis, arranging accommodation in nursing homes, or handing out bus tickets, is a sheer waste of talent and a misuse of personnel. To have an occupational therapist carry out tasks that could be conducted equally well by a craft worker is prodigal. To have a physiotherapist engaged in tasks fit for a masseuse results from an inexcusable "ready-to-wear" attitude. To have a nurse trained in this age perform many of the tasks undertaken by the nurse trained in the "good old days" fails to recognize that times change. To have health institutions planned, developed and "insulated" in the same way they used to be is to cling nostalgically to the horse-and-buggy.

Before we can learn how to handle the shovel we found in our jungle, we must determine the talents of Peter and Paul in order to make the most effective use of them. Restorative medicine requires such a large number of talents that their use requires careful planning. To do less than is necessary would be an unhappy commentary upon our efforts to meet the demands for health services.

Job-tailoring cannot be achieved solely by the institutions. The professionally-trained person and his association must bear a good deal of responsibility. Especially in restorative medicine is there need to establish interprofessional relations so that each profession may learn to integrate its services into the team approach to the care of the patient. Barriers of professional hypersensitivities do not encourage effective use of personnel. No profession is free of blame for the unsatisfactory state of understanding that exists between members of the rehabilitation team. It is to the credit of individuals from the various professions that many individual teams have worked out their problems of co-ordination. Nevertheless, co-operation would have been made quicker and easier had there been less insularity at professional association levels. But the methods of achieving togetherness will re-

(concluded on page 88)

Manitoba Hospital and Nursing Conference

W. Douglas Piercey, M.D.

THE sixth annual Manitoba Hospital and Nursing Conference was held October 29-31, 1957, at the Royal Alexandra Hotel, Winnipeg. Some 1,260 delegates registered from ten organizations. Mrs. A. M. Oswald of Winnipeg was general chairman and R. G. Goodman, conference secretary and exhibit manager.

The conference embraced meetings of ten separate organizations —The Associated Hospitals of Manitoba; Manitoba Association of Registered Nurses; Manitoba Women's Hospital Auxiliaries Association; Manitoba Public Health Association; Manitoba Association of Licensed Practical Nurses; Manitoba Association of Medical Record Librarians; Manitoba Division, Canadian Society of Radiological Technicians; Manitoba Branch, Canadian Society of Laboratory Technologists; Manitoba Division, Canadian Society of Hospital Pharmacists; and the Dietetic Association of Manitoba.

The conference consisted of general sessions and sectional meetings. Highlights of the general sessions were an address by the Hon. R. W. Bend, Minister of Health and Public Welfare for Manitoba; a panel discussion on the spiritual aspects of hospital care; and the topic "A Look at Tomorrow".

Meeting as a section, the Associated Hospitals of Manitoba sponsored a "Hospital Circus" where five simultaneous demonstrations were given, *e.g.* Menu planning. The 32nd annual meeting of the association took place on Wednesday morning; and Thursday afternoon was given over to the discussion of papers on the topics "The Hospital Package and its Cost" and "The New Era in Voluntary Effort". At the conference dinner, held Wednesday evening, the guest speaker was the Reverend W. C. Lockhart, D.D., Ph.D., Principal, United College, Winnipeg. His subject was "The Parson Talks Back".

The Hon. R. W. Bend had hoped to bring to the convention the present views of the government of Manitoba on hospital insurance. Because this was currently under intensive review, and the cabinet had not made final decisions, he was not in a position to speak on the subject. He addressed the conference instead on general impressions he has formed since becoming Minister of Health. He was pleased that in a world which is becoming increasingly materialistic there are so many health workers who are not just interested in personal financial gain. Ignorance and disease are twins that have to be defeated. No department of health can function without an active partnership with voluntary organizations, the Minister said. While it is of value to look back and necessary to look to the future, three things stand out at the present time in relation to health care. First is the immensity of the problem and the importance of the field in which health workers are involved. In the realm of prevention, the magnitude of the problem is brought home, he said, when one considers the number of ills that afflict mankind. In the field of health economics, hospital care is becoming increasingly important for all people.

Spiritual aspects of hospital care was the subject of an address by the Reverend F. M. Norstad, professor of theology, Luther Theological Seminary, St. Paul, Minnesota. A panel discussion followed. Those participating were the Rev. Norstad; the Reverend J. T.

Officers and Directors for 1957 - 58

Front row, left to right: J. E. Gardner, Dauphin; Judge J. Milton George, Morden; Frank Foster, Brandon, 1st vice-president; J. E. Robinson, Winnipeg, president; T. A. J. Cunnings, Winnipeg, immediate past-president; John M. McIntyre, Winnipeg.

Back row, left to right: Robert Goodman, Winnipeg, executive secretary; J. C. Friesen, Morris; Nelson Shoemaker, Neepawa; G. B. Rosenfeld, Winnipeg; J. M. Klassen, Steinbach; R. J. Hood, Carberry; Allan K. McTaggart, Brandon; A. J. Schmiedl, Dauphin; W. T. Andrew, Hamiota. (Absent from the picture are G. T. Potvin, Mrs. A. M. Oswald and Dr. L. O. Bradley, all of Winnipeg).

The Rev. F. M. Norstad, Luther Theological Seminary, St. Paul, Minn., speaks on the spiritual aspects of hospital care.

Wotton, of the United Church, Winnipeg; Father Raymond Durocher, O.M.I., spiritual advisor to the Catholic Hospital Conference of Manitoba; Rabbi Jack Garland, Zedek Synagogue, Winnipeg; and Dr. John Matas, psychiatrist at St. Boniface Hospital. This session held the interest of a large audience which included many visiting clergymen. The fact that the program committee deemed it advantageous to have such a discussion, and the response of both those taking part and the audience, emphasizes the importance of this topic today.

Under the general theme of "A Look at Tomorrow", A. L. Williams, research economist, Department of Public Health of the province of Saskatchewan, gave a paper on "Do Today's Hospital Statistics Indicate Tomorrow's Health Needs?" This comprehensive paper does not lend itself readily to summary in a news report and will be published in its entirety in a subsequent issue of *The Canadian Hospital*.

Dr. V. L. Matthews, branch director, Medical and Hospital Services, Department of Public Health of Saskatchewan, outlined his province's experience in the administration of a provincial hospital insurance plan; and G. B. Rosenfeld, administrator, Victoria Hospital, Winnipeg, presented a paper on "A Look to Standards". Dr. Matthews outlined the cardinal principles under which the Saskatchewan plan, dating back to 1947, was organized. The speaker cautioned that Saskatchewan experience might not be applicable elsewhere in Canada. He enumerated the five principles guiding the operation of the Saskatchewan plan: (1) coverage of the population should be as comprehensive as possible; (2) the cost should be balanced between individual and government sources—approximately 50 per cent is paid for by the insured; (3) service should be as comprehensive and at as high a standard as possible; (4) the autonomy of each hospital must be maintained; and (5) hospitals should be paid full cost of operation.

In considering standards, Mr. Rosenfeld underlined the rising cost in hospital care and the increased use of hospitals. Success or failure of a government-sponsored hospital plan does not rest solely with government, and rising costs are part of the current inflationary trends. The price of goods purchased by hospitals and salary schedules are determined in relation to wages in the community.

In discussing "The Hospital Package and its Cost", Donald W. Cordes, administrator, Iowa Methodist Hospital, Des Moines, Iowa, stated that hospital costs actually went up 223 per cent in the United States in the past decade, and were increased by nine per cent in 1956 over 1955. The speaker believed that hospital people should refer to the cost per admission rather than the cost per day. One cause of increased hospital costs is that more highly skilled employees are needed and have been added to the hospital family. More employees are required, due to the shorter work week; there is thus an increase in the total number of employees required, and, due to the reduced stay of patients, more intensified care is rendered per day per patient. The real reasons for the sharp rise in hospital costs lie in a fundamental change in the treatment of the patient. There is much evidence of increased specialization among employees and many hospitals in the past decade have added to their staffs highly qualified chemists, bacteriologists, and psychologists. Also employed are more full-time spiritual advisers, more occupational and recreational therapists. Ninety per cent of the drugs used in the hospital today were unheard of ten years ago. Intensified treatment requires much new equipment, more building space, and a more complex administrative team. In looking to the future of the general hospital, the gaining of knowledge will continue and at an accelerated rate, the speaker said. He believed that

Left: left to right are D. Hejlsted, Clearwater Lake Sanatorium; Marjorie G. Dunn, Hamiota District Hospital; M. Pearl Stiver, of the Canadian Nurses' Association; and A. J. Gordon, Winnipeg Municipal Hospitals.

Right: W. J. Hamblin, Morris, seated on the left, with R. J. Hood of Carberry (centre) and L. Careless of Emerson (right) chat between sessions.

hospital investment per bed would continue to rise. It would be necessary to have more educational training programs within the hospital, and one area where this would have to be especially intensified was that of supervisory training. The speaker believed that amalgamation of institutions in many instances could produce economies. The length of stay per illness, he thought, has been reduced to about the minimum. It is necessary to improve the quality of administration, and more time must be given to planning for the future.

John P. Labatt, general manager of Shea's Winnipeg Brewery, Ltd., spoke on the new era in voluntary effort. The speaker drew from his experience as a trustee of the Misericordia General Hospital. He asked "How do trustees gain the maximum support for their hospitals?" The answer lay, he believed, with the owners, the medical staff, and the administrator of the hospital. Much depends, he said, upon the calibre of the board of trustees. Mr. Labatt posed several questions to the audience, such as "Should boards be enlarged to achieve better community support?" "Should boards participate more in the day-to-day administration of the hospital?" "Should all hospitals have ladies' auxiliaries and assign tasks to them?" and "Should trustees have their own association?"

In his presidential address, T. A. J. Cunnings stated that as hospital insurance was such a widespread topic of discussion throughout Canada at the present time, and as the matter was under active review by the government of Manitoba, the association, after a necessary period of study and research, had presented a brief to the Hon. R. W. Bend, Minister of Health and Public Welfare, on May 16 of this year. The brief outlined the views of the association on the general principles of administration of any plan that might be established in the province. The committee that prepared the brief, along with the president, included J. E. Robinson, Dr. L. O. Bradley, G. L. Pickering, and R. G. Goodman. The brief outlined the following six principles:

(1) The association believes that local ownership, management and control of hospitals should be continued with responsibility remaining in the hands of local communities and charitable organizations. It is essential that opportunity should remain for individuality in development and operation of hospitals within a framework of acceptable standards.

(2) The association feels that the administration of the hospital care plan could seek, with advantage, the opinion of an advisory board, which might be composed of nine members as follows:

Municipalities (urban and rural)	2
Manitoba Medical Association	2
Associated Hospitals of Manitoba	2
Citizens at large	3

(3) Benefits should be available to all residents of the province and should include in-patient diagnostic services; standard ward care in active treatment hospitals, convalescent hospitals and hospitals for the chronically ill; and out-patient diagnosis and treatment.

(4) Radiological and laboratory services should continue to be integral aspects of patient care in hospitals. Arrangements between the hospital and the individual or group supplying professional services should remain a matter of negotiation between the parties concerned. Hospital-centred diagnostic services for both in-patients and out-patients must be included as an integral part of hospital care. It is realized that the medical profession must provide these services and a mutually acceptable arrangement must be evolved.

(5) Methods of payment to hospitals should fulfill the following objectives: (a) should not create an unnecessarily heavy administrative burden; (b) should encourage an ever improving standard of care, consistent with economy, and facilitate the co-ordination of various health services; (c) be subject to simple measures of control against abuse; (d) meet the needs of budgetary and financial management. Specific suggestions were made in the brief as to a method of payment meeting these requirements.

(6) The plan must provide for the payment of all hospital costs either through the insuring agency or through legislative authority for recovery of costs not covered in the basic plan. Special submissions were made with regard to payments to cover interest and depreciation, and with regard to working capital requirements.

Nursing

During 1957 an acute shortage in the supply of nursing personnel in Manitoba became evident. In an effort to examine the problem and bring forth recommendations that would bring about basic and long-term improvement in the situation, a joint committee on nursing was established, under the chairmanship of Dr. L. O. Bradley. Members included representatives of the Manitoba Medical Association, the Manitoba Association of Registered Nurses, the Junior Chamber of Commerce, the University of Manitoba, the Association of Lic-

ensed Practical Nurses, the Department of Health and Public Welfare, the Department of Education, and others. As a result of preliminary studies of the Joint Committee on Nursing but initiated by the Winnipeg Regional Hospital Council and recommended through the Association, an increase of $20 per month from the old basic rate of $210 per month, for registered nurses, was made widely effective on October 1, 1957. Where the hospital was willing and able to do so, it was hoped to increase the basic rate another $20 per month on April, 1, 1958, bringing the rate to $250 per month. The president stated that this would bring the remuneration of registered nurses more in line with that being offered in other fields of endeavour, bearing in mind the relatively long period of preparatory training. At the same time the five-day, forty-hour week will be extended to include many more hospitals than the few that now have it in effect. In view of these much needed improvements in working conditions, nurses and other personnel, as well as trustees and administrators, should be aware that perquisites and other traditional allowances that were established in the days of the 48 or 56-hour working week must be re-assessed in the light of modern policies and practices. It was hoped that improved personnel policies for nurses would retain in the province a larger proportion of graduating students. In 1957 there were 487 new student nurses enrolled in Manitoba, as compared to 422 in 1956. It was anticipated that there would be 500 or more students enrolled annually for the next few years. The Department of Education figures indicated that there was an increase of 2,500 in grade 11 and 12 enrollment in the five years up to 1956, and the number continues to increase. Consequently, the potential number of student nurses is growing and since under present conditions hospitals have the responsibility for providing facilities for nursing education, it will be necessary to provide adequate accommodation for future needs.

Mr. Cunnings said that Manitoba was fortunate in having a well-established system of training licensed practical nurses. In the light of current and probable future demands for nursing personnel, the place of the licensed practical nurse in the patient care program probably needs to be reassessed. It appears that the annual output of practical nurses should be substantially increased.

The directors recently established a committee, under the chairmanship of G. L. Pickering, to consider the possibility of covering all hospital employees with Workmen's Compensation. Up to the present time only limited coverage of selected groups at relatively high rates has been possible. Mr. Cunnings also reported that the system of inclusive rates which became effective April 1, 1957, had been inaugurated without a single important difficulty being encountered.

Costs

Hospital budgets, now being prepared, would in most cases cover the period to March 1, 1959, to correspond with the government fiscal year, as prescribed by the Rate Board. The president stated that, in view of careful cost estimates, it would appear that rates would be increased 15 to 20 per cent in the new budget period. About 5 per cent of these increases are occasioned by general inflationary trends. Social forces are changing salaries and hours of work, raising the standard of care, and creating demands for new services. These inevitably lead to the spending of more money which can come from only one source—the patient, whether his bill is paid directly or by an agency. Mr. Cunnings stated that hospital administrators and trustees had an obligation to ensure that adequate value was obtained for these expenditures and that a continuous program of review, research and consultation go forward to achieve efficiency in hospital operation. They must see that personnel are used economically according to their talents; that labour saving methods are introduced where this is possible; and that the best management techniques are applied.

The president stated that he was happy to report that relations between the Associated Hospitals of Manitoba and the provincial government remained on a basis of mutual confidence and respect. To maintain a convenient and important liaison in the period ahead, it was recommended that a standing committee on government relations be appointed and that the Manitoba Catholic Hospital Conference be asked to name one member to this committee. Relations with Blue Cross continued on a very satisfactory basis. The third party payments committee, under the chairmanship of J. E. Robinson, again successfully completed negotiation for contracts between member hospitals and the Manitoba Hospital Service Association and

A group from the Grace Hospital, Winnipeg. Left to right are Capt. Kollin, Capt. Gladys McGregor, Miss Fletcher, Miss M. Leithead, and Brig. Gladys Gage.

Left to right: C. A. Cavanaugh, Department of Public Health of Manitoba; Sister Régina Trottier, St. Rose du Lac; Sister Susanne Gauthier, and Sister J. Poulin, The Pas; with G. W. McCaffrey, Manitoba Blue Cross.

the Workmen's Compensation Board. The Report Accounting Committee, under the chairmanship of J. M. McIntyre, again guided successfully this important and growing program that has for the first time brought many hospitals the accounting advantages that permit adequately informed decisions to be applied in their management.

The Women's Hospital Auxiliaries and Guilds in Manitoba are doing magnificent work in making contributions of money, equipment and supplies to our hospitals, said the president. He paid tribute to the generous warmhearted assistance made without thought of personal reward.

Secretary's Report

R. G. Goodman reported that the association membership now included close to 100 per cent of Manitoba hospitals. Thirty-three hospitals, totalling some 800 beds, are enrolled in the Report Accounting Program. Mr. Goodman said that this was the first year that hospitals participating in the program had been asked to pay their share of cost of the program. The original three-year term of assistance by the W. K. Kellogg Foundation expired in 1956. However, the Foundation had agreed to a further two years' assistance for specific new features of the program. The interim assessment in 1957 amounted to an average of 15 cents per patient day for all hospitals in the program. This represented no more than 1.5 per cent of the budgets of these hospitals. Mr. Goodman stressed that the program of Report Accounting was not replacing some other method of book-keeping. The association is trying, he said, to provide a service that could not be duplicated individually, except at a much higher cost. The secretary believed that the strength of the program lay in the fact that a large number of hospitals were represented. An ever increasing store of hospital financial data is being accumulated and the hospitals collectively can do much that would be difficult if not impossible for each hospital to do alone.

Demonstrations

Five simultaneous demonstration areas were set-up in the Crystal Ballroom. One pertained to the cutting, buying, and cooking of meat. This included the cutting of a side of beef—through the courtesy of Canada Packers Limited. Medical records were demonstrated by the Manitoba Association of Medical Record Librarians. A demonstration of physiotherapy and the nurse was shown by the staff of Winnipeg Municipal Hospitals. Menu planning was under the Dietetic Association of Manitoba; and the Report Accounting Program was on display.

Hightlights of the sectional meeting of the Manitoba Association of Registered Nurses were an address by M. Pearl Stiver, general secretary-treasurer, Canadian Nurses' Association, on the topic, "Balance in an Unbalanced World", and an address by Dr. George C. Sisler, professor of psychiatry, Manitoba Medical College, on "The Nurse and the Emotional Needs of the Patient".

Officers Elected

Hon. president, The Hon. R. W. Bend, Minister of Health and Public Welfare; *Immediate past president*, T. A. J. Cunnings, Winnipeg; *president*, J. E. Robinson, Winnipeg; *1st vice-president*, Frank Foster, Brandon; *2nd vice-president*, Dr. L. O. Bradley, Winnipeg; and *Hon. treasurer*, G. T. Potvin, Winnipeg.

Resolutions

WHEREAS the Hon. Robert Bend, Minister of Health for Manitoba, in his address at the opening session of this convention, stressed the enormity of the problem facing the government in formulating legislation to meet the needs of the province with reference to hospital care insurance as proposed by the federal government,

AND WHEREAS he fully recognized the need for continued voluntary effort in the future as in the past, stating a well-known fact that people can do things for themselves far better than any government can do it for them,

AND WHEREAS he urged against too hasty action in a matter of so grave importance, and that a solution could only be found by utilization of all the knowledge available from all sources, including that of this association,

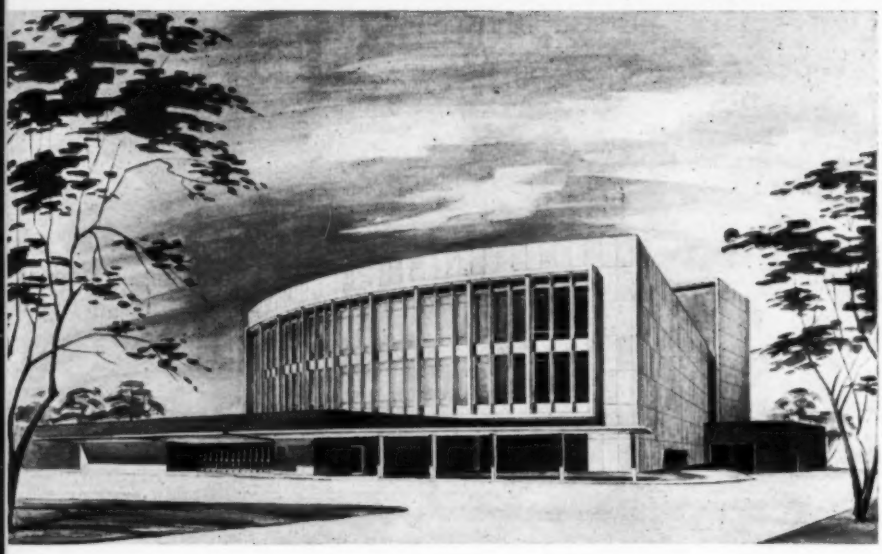
AND WHEREAS he recognized the important part played by the Associated Hospitals of Manitoba in the field of hospitalization, and stated that he would welcome any assistance this association could give him in the future,

AND WHEREAS this association does appreciate the careful study given this matter by the Minister of Health, and recognizes the basic principles that must be taken into consideration before finalizing any legislation that might be to the best interests of the people of this province,

THEREFORE BE IT RESOLVED that this association express to Hon. Robert Bend, Minister of Health for Manitoba, its thanks for his timely address, and for the leadership he is giving to the people of Manitoba by the careful consideration of a matter of prime importance to the people of this province,

THAT we do appreciate the recognition he has given to this association for the important part it has played in the past in the field of hospitalization, and his request for

(concluded on page 66)



Alberta Convention

In the new Jubilee Auditorium

W. Douglas Piercey, M.D.

THE 14th annual convention of the Associated Hospitals of Alberta was held in the Jubilee Auditorium, Edmonton, October 22-24, 1957. This newly completed building has every facility for holding a convention, including ample exhibition space and several large and small rooms for meetings.

Although a widespread snowstorm which occurred the day before the meeting made travelling from some areas of the province difficult, some 300 delegates registered for the three-day session.

Sectional meetings were held for secretaries, board members, matrons and chronic hospital personnel. The presidential address was given by S. V. Pryce of Holy Cross Hospital, Calgary, and the secretary-treasurer's report by L. R. Adshead of the University of Alberta Hospital, Edmonton. Chief Judge N. V. Buchanan reported on the Canadian Hospital Association's biennial meeting held in Saskatoon in May, 1957. The work of the national association was discussed by Dr. D. F. W. Porter, president, and Dr. W. Douglas Piercey, executive director of the Canadian Hospital Association. The Associated Auxiliaries' report was given by Mrs. E. Wershof.

Mr. Pryce stated that relations with the provincial government and the Associated Hospitals of Alberta are on a new high level. The Department of Health had asked, and received, the viewpoint of hospitals. The association was requested to present a brief to the Planning Committee, and the officers of the Alberta association were extremely pleased with development of the provincial hospital insurance plan. Mr. Pryce reported that all approved hospitals of Alberta are members of the association, as are many chronic hospitals. Most regional conferences had been active, he said, and the program for the convention had been influenced by regional meetings. The board of directors had met on six occasions during the year and, among other matters, had approved erection of a building by the Alberta Blue Cross Plan. Mr. Pryce reported, also, that the directors had endorsed a second school in Alberta to train nursing aides.

This it was hoped would double the number of certified aides being trained each year. Two meetings had been held with the Red Cross Blood Donor Service and a committee of the board was studying labour unions in Alberta hospitals. Also considered by the board were the rôle of the Alberta Association of Registered Nurses in relation to the hospitals of Alberta, the list of excluded drugs, hospital operating costs, and a fee

schedule for radiological services. The question of a full-time secretariat for the Associated Hospitals of Alberta, although still under advisement by the board of directors, is not to be established at this time. The president expressed the thanks of the association to L. R. Adshead, secretary-treasurer.

Mrs. E. Wershof, in reporting for the Associated Auxiliaries, said they were working in the field of social service. Many social needs of the patient must be met and hospitals could delegate some of this work to auxiliaries, she suggested. The speaker thought auxiliaries should be represented on the boards of trustees of hospitals. There are now over 50 auxiliary chapters in Alberta hospitals, with a membership of some 1,300. In many communities the auxiliaries try to make the life of the nurse away from home more pleasant. Many auxiliaries operate a book cart service for patients, and do sewing in some institutions. Public relations were stressed in all auxiliary programs. The speaker foresaw a stronger and more unified rôle to be played by auxiliaries in Canada. She expressed her thanks on behalf of her members to the board of directors of the Associated Hospitals of Alberta for their co-operation.

Dr. J. B. Ross, newly appointed Minister of Health and J. D. Campbell, director, Hospital Division, Department of Public Health, discussed various implications of the enlarged hospital insurance plan for the province of Alberta. The Minister stated that Bill 101 was a hospitalization plan for all the people of Alberta and that it was the government's intention to implement the bill on April 1, 1958. Only acute hospital care will be covered at the outset and hospitals will receive payment in total for authorized costs. The Minister stated that, with the continued advice of the Associated Hospitals of Alberta and related groups, it is the hope of the government to bring to the people of Alberta a plan second to none in Canada. The Minister was certain that both the hospitals and the government would approach the plan in the spirit of mutual co-operation, not asking "who is right" but "what is right".

Professor Campbell said it was proposed that the cost of operation of hospitals in Alberta would be met by the provincial government, the patient and the municipality. Detailed interpretation of Bill 101 would still have to be worked out and interested groups would be asked to set up committees. Rates for non-eligibles would be the rates the hospitals are now charging. Capital charges will be included in the usual rates charged by hospitals and probably there will be a uniform rate for adults and children. The provincial government will cover newborns for a stay of not more than 12 days. Psychiatric cases will be covered when they are in general hospitals, and the province will accept co-insurance on maternity patients. Bad debts should practically disappear, and those incurred will be chiefly from the deterrent charge. It was quite possible that the government would approve a procedure whereby hospitals which followed an approved collection procedure, after six months would be reimbursed for fifty per cent of outstanding bad debts, thereafter the hospital would be entitled to collect 100 per cent of the debt if possible. Courtesy discounts would be wiped out and out-patient charges would not be covered under the plan. Hospitals will be reimbursed monthly. Training costs are part of hospital costs under the plan.

Dr. David Lander of Black Diamond, in a very interesting paper on "Mind over Matter", stressed many aspects of psychosomatic medicine. He reminded his audience that unhappiness can make people ill and that in our daily living a person must strive to get along with people. Two out of three of the patients which the average physician sees in his office have symptoms arising from an emotional basis. Examples included those related to peptic ulcer, asthma, and acne. Dr. Lander stated that many patients could be helped when the origin of their condition was primarily emotional—if someone would just take the time to listen to them patiently.

Top: left to right, S. L. Stulz, Cardston Municipal Hospital; G.W.Hanna, Colonel Belcher Hospital, Calgary; J. C. Robertson, Brooks Municipal Hospital; Clarence J. Wight and E. E. Nelson, both of Cardston Municipal Hospital.

Bottom: left to right, M. M. Dyck, G. S. MacKenzie, Gertrude M. Hall, H. P. Wright, and Dr. J. C. Johnston —all from Calgary General Hospital.

Dr. D. C. Ritchie of Edmonton recommended the use in rural hospitals of a new type of record for the newborn. This would permit research on the study of perinatal mortality. A committee has been established to study all perinatal deaths and many rural records are now inadequate for this type of study. The record forms suggested have been in use in three Edmonton hospitals for the past three years.

J. A. Monaghan, executive director of the Alberta Blue Cross Plan, reported on activities during the past year. He answered many questions regarding current operations and gave detailed explanations regarding coverage for railway employees under the national contract.

Rehabilitation

An interesting and informative panel discussion was held on rehabilitation. The panel moderator was Dr. A. C. McGugan, superintendent of the University of Alberta Hospital, Edmonton. Members of the panel were Dr. M. C. Adamson, Dr. K. A. Yonge, Dr. M. T. F. Carpendale and Dr. J. R. Fowler.

Dr. McGugan stated that rehabilitation, like every other phase of medical care, calls for team work on the part of a number of professional people especially trained in different avenues of approach. An adequate rehabilitation program calls for the participation of psychologists, social workers, speech therapists, educationalists and many others. Rehabilitation implies the treatment of the patient as a mental, physical, social, moral, and emotional entity. Unless the rehabilitation team has a thorough and complete knowledge of a patient's home and social problems, generally, and unless the team has a knowledge of how the patient will think, feel and act, under all sorts of circumstances, the team cannot be fully effective in helping the patient.

Speakers indicated that the emphasis is shifting from disease to disability. Rehabilitation implies treating the whole patient. As far as many chronic conditions are concerned, we are moving from custodial incarceration to active therapy. An increasing interest in disability and disease, both mental and physical, and an increasing toll of traffic accidents, are focusing attention on the rehabilitation program.

At least 20 per cent of the cases in the general hospital should have some measure of care under physical medicine. This, it was pointed out, will ensure a shorter period of convalescence, and more complete restoration of function to injured joints, muscles, tendons and nerves. Rehabilitation medicine includes care of strains, sprains and fractures, and in skin conditions, such as burns and psoriasis. It includes care also in organic disease and circulatory disease from peripheral vascular to cardiac disease. Also included are pre- and post-operative care, from knee to chest surgery, and anti- and post-partum care. A large arthritic group from the osteo-arthritis of the elder patient to rheumatoid arthritis need varying care in acute and chronic stages. It also encompasses care of the spastic child, and those cases needing long care, such as the polio case, multiple sclerosis, and many psychiatric cases.

All patients with residual disability after their medical and surgical treatment require eval-

Top: left to right, J. Stanford, Cardston Municipal Hospital; Dorothy E. Reid, Katherine H. Prittie Hospital, Bonnyville; Helen Hourihan, Three Hills Municipal Hospital; and Mrs. C. Burke, Turner Valley Municipal Hospital.

Middle: left to right, Dr. Irial Gogan, medical director of the Holy Cross Hospital, Calgary, chats with Dr. D. F. W. Porter, president of the Canadian Hospital Association; L. R. Adshead, of the Associated Hospitals of Alberta; and Dr. D. R. Easton, medical superintendent of the Royal Alexandra Hospital, Edmonton.

Bottom: left to right, K. Macalister, Red Deer Municipal Hospital; Mrs. Clara Van Dusen, of the Alberta Association of Registered Nurses; Mrs. V. L. Turner, Didsbury Municipal Hospital; and Mrs. E. Harvie, Lacombe Municipal Hospital.

Chief Judge N. V. Buchanan, Edmonton (left), congratulates Dr. David Lander (right) following presentation of the latter's paper "Mind Over Matter", while Dr. A. C. McGugan (centre) looks on.

uation to determine how independent they will be when they return to their own environment. When the areas in which a patient is dependent have been determined, the speakers indicated, a training program is started to try to enable the patient to accomplish the task unaided. If this cannot be done unaided, then various gadgets may be used. Only as a last resort is help from another person allowed because this spells dependency. When the patient can accomplish all these activities of daily living in the hospital environment, he is sent home and finds out what things he cannot accomplish there. Then a further round of training, possibly some of it in the home environment, is undertaken. Finally, if the patient is still dependent, modifications of the home itself may be required to render the patient independent.

To have a full rehabilitation program requires a diversified staff, adequate floor space and equipment. But, even a small hospital can make a start. Ten cases in one day is what the average physiotherapist can treat on a ward. In an equipped department, she can treat from fifteen to eighteen cases per day. In a hospital of medium size, the radiologist can act as the physical medicine director. A 50-bed hospital requires a room 30' x 24' and a minimum of equipment to carry on a program of physical medicine. Any city over 100,000 can support a rehabilitation team, panel members believed.

The afternoon of the final day of the convention was devoted to tours of the University Hospital and Workmen's Compensation Board Rehabilitation Centres, and a visit to the new Alberta Blue Cross offices.

Resolutions

A number of resolutions were considered by the business sessions of the convention. Time did not permit discussions on all those which the Resolutions Committee intended to present, and a number were referred to the in-coming Board of Directors for study and possible action. The following resolutions were adopted:

Out-Patient Services for Old Age Pensioners

WHEREAS there is presently no provision for payment of out-patient services provided by hospitals for Old Age Pensioners who are entitled to hospitalization benefits, except by the pensioner patient himself;

AND WHEREAS these costs quite often work a hardship on the pensioner, and when not paid, occasion considerable loss of revenue to hospitals;

AND WHEREAS the Province of Alberta maintains that pensioner hospitalization is provided through the Department of Public Health;

THEREFORE BE IT RESOLVED that the Associated Hospitals of Alberta through its executive again approach the Department of Public Health to have provision made for the said department to assume responsibility for the cost of Old Age Pensioners' out-patient diagnostic and treatment facilities provided by the hospitals.

Salary Schedule for Nurses

WHEREAS salaries paid to all classes of general-duty nursing personnel vary considerably in member hospitals; and charges made for maintenance vary and in no instance approach actual costs;

AND WHEREAS this proves a deterrant to stabilization of nursing staffs and therefore adversly affects hospital administration and nursing care;

THEREFORE BE IT RESOLVED that the Associated Hospitals in Convention, October 1957, be asked to approve the appointment by its directors of a committee to submit to member hospitals with all reasonable dispatch, a nurses' standard salary schedule and a standard evaluation of perquisites and suggested differentials.

Cost of Out-Patient Services

WHEREAS the Department of Health provides certain grants to cover cost of in-patient active treatment care, and the department expects that the hospital administration will not admit as active treatment patients those who can be treated as out-patients, and whereas cost to the patient for out-patient services are very great as compared to in-patient services and should therefore be more in line with the cost of in-patient services;

THEREFORE BE IT RESOLVED that the directors of Associated Hospitals of Alberta be asked to approach the Minister of Health to work out a solution to this problem by government grant or otherwise.

Regional Conferences

WHEREAS although regional hospital conferences have been established throughout the province, no provision for them has been made in the constitution of the Associated Hospitals of Alberta, and whereas it is felt that such provision would add unity and uniformity to the regional hospital conferences;

THEREFORE BE IT RESOLVED that the constitution of the Associated Hospitals of Alberta be amended to provide for the formation of regional conferences; and further, that it shall be deemed desirable for all hospitals which are members of the Associated Hospitals of Alberta to become members of their respective regional conferences.

Treatment of Long Term Patients

WHEREAS the Associated Hospitals of Alberta recognizes the urgent need for the immediate extension of facilities for the treatment of patients suffering from long term illness, and

WHEREAS because of the shortage of trained personnel and because of inadequate funds the rehabilitation of long term patients is being

(concluded on page 64)

A Year of Challenge

HOSPITALS must accept the challenge of the future—that was the theme which dominated the 33rd annual convention of the Ontario Hospital Association. The 2,220 delegates present at the sessions held on October 28, 29 and 30 at the Royal York Hotel in Toronto recognized that this year's convention was a momentous one; for it was seen that the future of hospitals in Ontario is bound up with the newly-legislated hospital insurance plan.

This fact was made clear from the opening session when Premier Leslie M. Frost told the delegates that the advent of the provincial plan would mean a greater taxing of the "realistic and prudent wisdom of hospital people". He also expressed confidence in the plan's effectiveness and in the integrity and capabilities of the Ontario Hospital Services commissioners—Arthur J. Swanson, Msgr. John G. Fullerton, Dr. John Neilson, and the three new appointees, Dr. Ian Urquhart, David W. Ogilvie, and Alister MacArthur.

The Ontario Hospital Services Commission, its activities and its connection with the new hospital insurance scheme, of course, was uppermost in everybody's mind. It was A. J. Swanson, speaking at the Monday afternoon session, who reviewed the commission's activities, past and present, and started the convention off with the discussion of the provincial hospital insurance plan and its meaning to the hospital people of Ontario. He enumerated the steps taken in evolving the plan from 1955 to the present time, during which time the unprecedented program has been drawn up, to operate under the commission's direction. "It is *your* program", Mr. Swanson said in appealing for complete hospital co-operation. "You control this plan through admissions and discharges; work with us, for its success will be a milestone in the hospital life of the community".

Getting more specific, E. P. McGavin, director of the Hospital Finance Branch, O.H.S.C., explained the arrangements that had been set up to pave the way for the insurance plan. "The next two years will present a challenge which needs the highest calibre of planning and control," he said. Mr. McGavin also explained the hows and whys of this planning, with particular emphasis on operating budgets, which will enable the insurance scheme to function efficiently.

He told of the "dry run" planned as part of the preparation, explaining just what the hospitals will be expected to do, and how the commission will fulfill its tasks. Every hospital was asked to submit a budget for 1958 by December 31, 1957, thereby giving hospital people the chance of becoming familiar with the various forms and procedures to be used. "And as problems arise on this trial run," Mr. McGavin stated, "help and guidance will be offered gladly by the commission."

Six regional conferences were being held, he said, at central points in Ontario during November and December to which hospitals were advised to send representatives to gain a clear picture of the procedure and to discuss their mutual problems.

The commission will be analyzing the returned monthly statements sent in by the hospitals, and so will be able to recommend any alterations to the hospital rate board. This method of budget analysis will serve as a check on expenditures and costs. Mr. McGavin enumerated the many items included in a budget as costs, including depreciation, bad debts, wages and salary increases, and set forth the formula (on a per diem standard ward bed basis)

Reported by
H. E. Goldsborough
and
Edwina King

Left to right: S. W. Martin, executive secretary-treasurer of the O.H.A., Toronto; H. M. Jackson, Simcoe, newly-elected president of the association; C. V. Charters, Brampton, president 1956-57; Premier Leslie M. Frost; and Toronto's mayor, Nathan Phillips.

to be used to determine how the commission will arrive at making payments to hospitals twice a month. "Budgets are one of the best tools for sound planning and control. We all want the plan to achieve the aim of a high level of patient care and efficiency under controlled costs—this is our challenge", he concluded.

Does the plan make a greater demand for beds in Ontario? No, claimed the Rt. Rev. John G. Fullerton, who presented the commission's views on hospital facilities. Seventy per cent of Ontario people carry some form of hospital insurance now, yet the beds are not filled, he stated. The commission wants to encourage the development of existing institutions where ever possible, rather than duplicate the facilities already available. What is feasible and sufficient to serve the community is the prime consideration that the commission must take into account in their survey of facilities. Although it is commendable for communities to want hospitals within their borders, it may not always be advisable, particularly in areas where patients can easily be transported a few miles to a nearby hospital. In the case that a new hospital is warranted, the commission will require assurance that firm bids have been received and funds are available, not only for construction cost, but also for architects' fees, equipment, furnishings, and landscaping, before granting approval.

The commission realizes that facilities do not stop with beds, but other services, such as treatment and diagnostic facilities are necessary for the best patient care —and just what facilities and where they are needed is being given serious study, Msgr. Fullerton said.

The commission can survey the whole hospital need situation only if hospitals co-operate willingly by giving the necessary information and statistics, under such headings as illness treated, length of stay, and hospital capacity. The commission will be able to use these statistics, also, as a basis for making decisions about any recommendations they may have to give regarding capital grants.

In his speech on the "1959 Approach to Prepaid Hospital Care", David W. Ogilvie, now director of the insurance branch of the commission, wanted to dispel the fear of "red tape" so often associated with government agencies, and he reviewed the steps by which prepaid hospital care has been transformed over the past two decades. "But", Mr. Ogilvie said, "partial payments, deductible, or some other form of co-insurance will be inescapable if everything possible is not done to keep the cost of the new hospital insurance plan within reasonable financial limits". Misuses must be guarded against.

The cost of the 1959 prepaid provincial plan is estimated at $210,000,000; with roughly one-third to be met by the province, one-third by the federal government, and the remainder by direct premiums.

The plan will provide broad coverage in all general, Red Cross, convalescent, and chronic hospitals, and in mental institutions and tuberculosis sanatoria which have been designated as approved by the commission. Nor will there be restrictions on the length of stay, medical need being the criterion for both admission and discharge. Details of the premium payment were outlined along with a re-payment system devised to cover unemployment and "hard times" periods.

"As to benefits available", Mr. Ogilvie said, "hospitals will be relieved to know that payments by the plan on behalf of the insured persons will be based upon the full cost of standard ward care. Full cost will also be paid for all 'indigent' cases, and we know that this feature will be welcomed by hospital boards of trustees and administrators who, throughout

Left to right: A group of Windsor delegates—Dr. David R. Brown, Fred Gilmore, Mrs. T. E. Armstrong, Stan Johnston, and Mrs. J. C. Bonham, discuss the convention program.

George Mason, Ontario Hospital Services Commission, with Sister Margaret Ann, Sister St. Thomas, and Sister Rosanna, all of Toronto, look over some of this year's O.H.A. publicity.

Shown at the presentation of the Robert Wood Johnson Award (from left to right) are: Dr. G. Harvey Agnew, professor of Hospital Administration; P. W. Remmington, representing Johnson and Johnson; Moshe Katz, honoured as this year's most promising graduate in hospital administration; Eugenia M. Stuart, associate professor; and Dr. Andrew Rhodes, director of the School of Hygiene, University of Toronto.

the years, have suffered under a system which required hospitals to provide full services in return for payment of some amount considerably less than the cost of services".

All in all, it has been a busy year for the commission. It has also been a busy year for the Ontario Hospital Association. C. V. Charters, president of the O.H.A. for 1956-57, gave an account, in his report, of the O.H.A.'s close relationship with the Hospital Insurance Plan and with the O.H.S.C. He outlined in detail the effects on the association of the past year's significant changes in hospital affairs. Future Blue Cross policy, Mr. Charters claimed, will confine itself to supplementary hospital coverage. Reports of other projects completed during the year—cost analysis of hospital care, and the two-day public relations institute—were given, and the announcement that an all-Canadian program of hospital accreditation was to go into effect in January 1959 was received with applause.

However, all was not serious discussion at the convention; many old friends met again and new acquaintances were made, profitable and informative visits were made to the manufacturers' exhibits, and enjoyable luncheons proved to be the time to talk over mutual hospital experiences for almost every delegate attending.

At the opening luncheon P. W. Remington, assistant vice-president, Hospital and Professional Division, Johnson & Johnson Co. Ltd., and Dr. Andrew Rhodes of the School of Hygiene, University of Toronto, presented the Robert Wood Johnson Award to Moshe Katz as the most promising member of the graduating class in hospital administration.

Trends in Hospital Design

How long does it pay to use old buildings? Not long at all, answered Dr. J. Gilbert Turner, executive director of Royal Victoria Hospital, Montreal, — not one unnecessary day. Deciding whether to bring present buildings up to date, or to build a new structure planned for the future, is, however, largely a question of economics.

Dr. D. F. W. Porter, president of the Canadian Hospital Association, defined economy as expendi-

Top: left to right are Marjory R. Riddell, Toronto; N. R. Dearlove, Cobourg; Alice Little, Palmerston; and Mrs. J. E. Porteous, St. Catharines.
Bottom: left to right, T. F. Murphy, Wallaceburg; J. S. Renton, Wallaceburg; Dr. C. J. Kirk, London; and S. W. Martin, Toronto.

ture to advantage, incurring no waste. It applies to expenditure of time and effort, to avoidance of accidents, as well as to finances. It is economical to save nurses' steps and patients' anxiety. "I refer to the trend . . . of concentrating the more complicated and more gravely ill medical and surgical cases in special observation and treatment areas". While these areas would require the continual observation of the more highly trained members of the nursing team, the majority of patients would require only the simplest of bed nursing care. Not only would care be where it was needed and nurses' steps saved, but most of the rooms for patients could be reduced in size and equipment. As a reduction of both initial and operating costs, this would be an economy.

As an economy in operation, R. F. Armstrong, superintendent of Kingston General Hospital, suggested heat exchange. Transferring heat from used water in the laundry to the fresh water would require little capital outlay, and would be a notable saving. The extra cost of a private room, he felt, was worthwhile for the patient, and welcome to the hospital. He recommended careful food planning, and new methods of preparation and preservation. Since the maximum use of beds depends on the service load for the facilities, Mr. Armstrong recommended planned capital expenditure for equipment as a sound investment for present operation.

"The biggest problem is not merely to be up-to-date," said Dr. G. Harvey Agnew, of Agnew, Craig, and Peckham, Toronto, "but to so read the crystal ball that what we plan today, and open two or three years hence, will still be up-to-date ten years later." Dr. Agnew, foreseeing that hospital insurance will result in increased demand for accommodation and a broadening of services, felt that diagnostic services would have to be developed to make certain that the criterion for admission be necessity. Separation of patients according to the degree and type of professional care required is also in Dr. Agnew's suggestion that separate programs be arranged for patients with sub-acute or convalescent needs. This would allow the general hospital to handle acute patients and the many emergencies in an age of automation.

Intelligent planning in initial expenditure is the only way to put economy in operation into effect, Mr. Armstrong agreed. Plans which save foosteps, floor coverings which will last, windows that can be easily cleaned, laboratories which will not be obsolete almost by the time they are built, he felt, are investments. Dr. Porter recommended partitions which can be altered to new requirements and make buildings flexible for expanding diagnostic services. The administrator's time, he said, should be given to adapting the hospital to new methods and new demands. A bright, safe, happy atmosphere for staff and patients, he felt, is a hospital economy.

Deciding whether it is more economical to build or renovate is largely a matter for the individual hospital, said Dr. Porter. When demolition and rebuilding would be the alternative, and when renovation of the building is possible, it may be best to expand and modernize what you have. If the buildings are hopelessly inadequate and could not be adapted to new demands, it may be best to build on a new site. In judging whether a building is obsolete, the criterion is not age in years, but functional value.

Hospital construction is one of the fields mentioned by Dr. Agnew in which effective future planning is hobbled by traditional ideas. In adapting the structure to the site, purpose, budget and functioning of the hospital, the architect has a different problem today than he had years ago. The traditional vertical plan, said J. E. Owen, an architect with John B. Parkin Associates, Toronto, was dictated by a 30 to 35-bed nursing unit. What was efficient functioning for this unit is not efficient functioning for today's expanding services.

The horizontal plan used in modified form at the Greater Niagara General Hospital, Mr. Owen felt, is a better translation of new functions into the three dimensions of construction. With no basement, a less expensive frame, no elevators or duplication of lobbies and stairs, and with planned grouping of services, the new plan is designed for a fixed budget. Acutely ill patients are concentrated on the floor above the other services for most efficient care. Capable of 100 per cent expansion, this hospital was cited as an example of combining aesthetics, efficiency, and economy.

H. G. Hughes, Chief of the Hospital Design Division of the Department of National Health and Welfare, had introduced the discussion with the need for a new approach to the question of hospital construction. Today's problems are so far beyond the scope of yesterday's answers that we should return to the basic principles of function. Since the pur-

Left to right: Fred Whittaker, administrator of Western Memorial Hospital, Cornerbrook, Nfld.; H. G. Hughes of the National Design Division, Department of National Health and Welfare, Ottawa; M. B. Wallace, administrator of Toronto Western Hospital; and Dr. Harvey Agnew, director of University of Toronto's course in Hospital Administration.

pose of the nursing ward is to provide patients with service, care, and the reassuring personal proximity of the nurse, the ward should be designed so that the patient can see her. In a ward shaped like the hub and spokes of a wheel, with the nurse in the centre and the patients at the perimeter, the simplified rooms would contain only facilities necessary both day and night. Supervision by a small nursing staff, particularly at night, would be made easier and more efficient. In spite of difficulties with the slide projector, Mr. Hughes clearly demonstrated many of the ideas which have been developed by approaching hospital construction via fundamental purposes. Much as we need new ideas to meet new needs, Mr. Hughes cautioned that just being new does not make an idea good or bad—its value is in its workability.

The feeling that the new trends in hospital design, far from being superficial, are the attempted answers to rapidly changing and expanding demands was shared by each of those who spoke. Concentration of acute patients in particular areas for skilled care was recommended as a saving in time, money, and professional experience in hospitals of today and in the future. Sharing ideas, investigating others' experiences, willingness to try new methods, careful consideration of initial costs, durability, and efficiency, and flexible allowance for expansion are all vital to intelligent planning. "Then when you have the solution," as Mr. Hughes said, "let's hope you have the money to implement it."

Predicting Nursing Needs

More economical use of graduate nurses was urged by Marie Hudson, Director of Nursing at Hamilton General Hospital, as she opened the discussion of nursing needs. Now that the nurses are being given responsibilities which formerly were in the realm of the intern or attending physician, she should be relieved of some of her routine ward duties.

"Hospital nursing has become too complicated as a result of new methods and modern scientific procedures, and the functions the nurse formerly fulfilled in a ward have become too detailed and time-consuming for any one group to handle." Even if professional nurses were available in sufficient numbers to perform all nursing services, it would be uneconomical for them to do so. "It seems inevitable," she continued, "that the nursing needs of our time can be met only through an ever-growing group of auxiliary workers. The graduate nurse must assume responsibility for comprehensive nursing care of the patients with full utilization of the services of all other groups."

Now that the increased use of highly specialized equipment, the exacting care required for patients after delicate surgery, and the discovery of new drugs have aggravated the chronic problem of the nursing shortage, it is all the more important to use nurses economically. By allocating patients according to the degree rather than the amount of care required, experienced nurses could be devoted to severe cases and to supervision of nursing assistants.

Increasing the number of auxiliary workers to relieve the graduates of routine ward duties and paper work would require extensive revision of educational programs. A night or daytime program such as that offered by a London high school might give academic and clinical training to nursing assistants. Nurse training could be revised to prepare registered nurses to assume more responsibilities in both treatment and administration. Doctors and patients would also have to be educated to the new group of workers, the speaker said, and made to realize that graduate nurse power is best used where it is most needed.

The nursing shortage, severe in all hospitals, is a critical problem in smaller hospitals. Although the small hospital has much to offer a nurse, said Helen McCallum, consultant with the Hospital Nursing Service, Ontario Department of Health, it has difficulty in attracting the nurses.

"It is my firm conviction that hospitals of this size (75 beds or less) have more to offer the average patient and just as much to offer members of the nursing staff as larger hospitals." In a small hospital the nurse's duties are more varied. The "warmth and esprit de corps" of the smaller unit preserves the individuality of the nurse as well as of the patient.

Small hospitals have no schools

Sister Mary Evangeline, Pembroke (far right) shows Sister Catherine of Siena and Sister Teresa Agatha, both of Sault Ste. Marie, the "story" of Pembroke General Hospital.

Left: L. H. Parsons, and Mrs. D. J. Graham, of Oakville. Right: "Bill" Sharp of Ontario's Blue Cross (far right) in animated discussion with (from left to right) Bernard Holden, Mrs. A. Kavanaugh, and Marion Dunlop, of Deep River Hospital, Deep River.

of nursing, where students can learn the advantages these hospitals and their communities offer, or where the students can establish social contacts. Married nurses in the community who work part-time do much to alleviate the shortage, but it will take some changes in present methods to attract graduates from other centres. Social programs should be worked out to make the nurse feel wanted by the community. Opportunity to work in a small hospital should be included in the educational program so that student nurses could experience the place and the need they would fill in a small hospital.

That the program of nursing education would have to change if it is to answer the demand for more and better personnel was the theme of the discussion led by Edith M. McDowell, Dean of the School of Nursing, University of Western Ontario, London. Mary E. Macfarland, superintendent of nursing at Toronto General Hospital, E. K. Jones, superintendent of nursing in the Wellesley Division, and Dorothy Colquhoun, director of the School of Nursing at Metropolitan General Hospital in Windsor, discussed the practicablity of the accelerated training program.

Nursing education must be able to meet the changing concept of the nursing needs of society, said Miss Jones. The emphasis on the rehabilitation aspects of treatment and nursing care has resulted in educational objectives which stress the ability to communicate, interpret, and secure the co-operation of others. "We have tried to make the life of the nurse a more normal one, by a less authoritarian approach . . . We feel that she will have a more normal approach to the patients."

Miss Colquhoun outlined the accelerated program set up in her hospital. "From the beginning," she said, "attention is focussed on the patient, by permitting the student to give as comprehensive care as possible within the limits of her developing skills. Throughout the first two years a comprehensive nursing care plan is made for each patient, based on a consideration of scientific, psychological, and social factors." In this way nursing care is taught as more than a series of tasks. By the end of the second term, classroom work has been completed, and the student gives full-time comprehensive care to the obstetric and paediatric patient, with delivery room and further nursery experience. During the third and final year an in-service educational program includes contemporary nursing, ward administration, and team leadership seminars in nursing. "With the emphasis on the student as a learner, we are able to grade experience from the simple to the more complex, which helps to build self-confidence on a firm foundation."

Since changes are inevitable, said Miss Macfarland, they should be planned. And today's changes require not a rearrangement of the old pattern, but a new approach. Besides new facilities and new instructors, the accelerated program calls for changed attitudes. The less authoritarian approach to nurse education will require flexibility and mature judgment.

The panel fully agreed on the success of the accelerated plan. They each found that as well as training girls technically, it maintained student interest and enthusiasm for the nursing profession. They offered the organizational plan of the accelerated program, with its clearly stated lines of authority and responsibility, as a framework in which there is freedom for accomplishment, and as a positive step toward meeting today's critical shortage of nurses.

Medico-Legal Problems

Dr. Frederick Evis, medical legal consultant of the O.H.S.C., emphasized that the application of general principles of hospital organization and management would greatly increase the hospitals' chances of avoiding medico-legal problems in the future. He also gave a comprehensive list of possible medico-legal problems and concluded by outlining thirteen basic principles of how to avoid these situations.

Accreditation

The decision to embark on an all-Canadian accreditation program in January of 1959 was explained by Dr. J. B. Neilson at the last session of the convention. The program, which will involve complete separation from the activities of the present Joint Commission, will use only Canadian resources. In reviewing the history of the Canadian Commission on Accreditation, formed in 1953, Dr. Neilson said that its growth, along with the interest in accreditation shown by hospital governing boards and medical staffs, were main factors involved in the decision to take this important step. He also enumerated some of the ways in which hospitals might improve their qualifications for eventual accreditation, and told of the commission's plans for the immediate future.

Career Talk

Officers

Officers of the Ontario Hospital Association for 1958 are: *Honorary president,* Hon. Mackinnon Phillips, Toronto; *Honorary vice-president,* C. V. Charters, Brampton; *President,* H. M. Jackson, Simcoe; *President-elect,* Rev. James Ferguson, Barrie; *Vice-presidents,* Sister M. Imelda, London; Dr. J. E. Sharpe, Toronto; and M. B. Wallace, Toronto; *Executive secretary-treasurer,* S. W. Martin, Toronto.

Career Talk

Three hundred students of secondary schools in Metropolitan Toronto listened to Eugenia M. Stuart, associate professor of Hospital Administration at the University of Toronto, speak on "Hospital Careers."

Miss Stuart discussed points of interest to students considering careers with twelve representatives of the various hospital departments, each of whom wore the uniform of his department. The students were then given an opportunity to ask questions of the panel member in the profession which most interested them. The picture has captured the students' interest and enthusiasm.

Resolutions Adopted

Regional Surveys for Hospital Planning

WHEREAS the information on hospital facilities developed from the findings of the Health Survey Committee in 1950 is insufficient for present planning purposes,

AND WHEREAS one of the functions of the Ontario Hospital Services Commission is to develop adequate hospital facilities without unnecessary overlapping or duplicating of services, thereby utilizing funds and personnel to the fullest extent,

BE IT THEREFORE RESOLVED that the Ontario Hospital Association and its member hospitals pledge their support to the Ontario Hospital Services Commission in undertaking to conduct any appropriate surveys on a regional basis to assist hospitals in laying plans for their continuing rôles, including future expansion.

Support to the Ontario Hospital Services Commission

WHEREAS the Ontario Hospital Services Commission has enlisted the co-operation of the Ontario Hospital Association in the setting up of the forthcoming Hospital Insurance Plan,

AND WHEREAS this planning period has been, and is, marked by the closest rapport and liaison between these two organizations,

BE IT THEREFORE RESOLVED that the Ontario Hospital Association pledge its loyal support and continued co-operation to the Ontario Hospital Services Commission in order to bring existing plans to a successful conclusion.

Depreciation and Interest on Capital Debt

WHEREAS many hospitals have capital debt structures on which the payment for interest and carrying charges have been planned for through charges made for services provided patients,

AND WHEREAS depreciation on buildings has become a component of the operating costs of many hospitals,

BE IT THEREFORE RESOLVED that the Ontario Hospital Association continue to recognize the fundamental financial needs of hospitals in these respects, and view with concern the institution of any plan which does not make some provision for these items in its reimbursable cost formula.

Training for Fire Safety

WHEREAS the safety of patients and staff in the event of fire is a continuing responsibility of the individual hospital,

AND WHEREAS fire fighting and the evacuation of patients are skills that can best be developed by those who are trained and employed full-time on such activities,

BE IT THEREFORE RESOLVED that the Ontario Hospital Association explore, with the Fire Marshal's department of this province, the possibility of making available to any and all hospitals, on request, the services of a specialist team who would be qualified and in a position to assist such hospital staffs in achieving a satisfactory standard of knowledge and performance commensurate with their

responsibilities in such matters.

Grants Received

WHEREAS the provincial government in 1957 made available to hospitals, grants for nursing schools in the amount of $300 per student nurse, and rehabilitation grants in the amount of $200 per bed, in addition to the special grants for care of indigent patients,

BE IT THEREFORE RESOLVED that the Ontario Hospital Association, on behalf of the hospitals of this province, express its appreciation to the Government of Ontario and the Ontario Hospital Services Commission for these monies already provided, and in anticipation of similar grants for the same purposes for the year 1958.

Voluntary Assistance

WHEREAS the news media outlets of Ontario, the many foundations, the countless women's organizations and auxiliaries, service clubs, fraternal orders, business, industry, labour and all other organizations, as well as many individuals have given freely of their time and money for the benefit of hospitals, and their fellow man, in the community,

BE IT THEREFORE RESOLVED that the Ontario Hospital Association place on record its sincere appreciation to all who have assisted the humanitarian rôle of all hospitals in Ontario, both through personal service and financial contributions.

Resolution of Appreciation

BE IT RESOLVED that the executive secretary-treasurer be instructed to communicate with the proper officials, expressing the association's appreciation of the generous coverage of its general sessions by the press, radio and television.

BE IT RESOLVED that special recognition be conveyed to every exhibitor for their contribution to the convention's success, and

BE IT RESOLVED that thanks be extended to the Royal York Hotel for its courtesies and attentions.

O.H.A. Section Meetings

Nursing Administration

IN discussing "What responsibility means to the graduate nurse", Sister Francis De Sales of St. Michael's Hospital in Toronto defined responsibility as that for which one is answerable. She stressed that, for a beginning, student nurses should be given a reasonable amount of responsibility, their duties should be clearly defined, and they should be allowed time and freedom to fulfill these tasks. The speaker was of the opinion that a broad general education helps to prepare the nurse to assume responsibilities and find a deeper satisfaction in her work. Interests outside nursing—books, music, art—will enable the nurse to bring a new range of social vision to her patient, as well as a deeper understanding of his total needs, she said. The nurse must also maintain an adequate knowledge of new or changing methods, medications, or treatments. As a health teacher, she must herself be healthy and happy in her work. "To the hospital, or agency of employment, the conscientious graduate sees her responsibility as an important member of a staff; a vehicle of public relations conveying to the community a message of service to mankind," continued Sister De Sales. She stated in conclusion that the challenge of responsibility in the professional nurse calls for loyalty, moral and intellectual competence, and a keen interest in upgrading professional standards of nursing.

"A health service program for hospital personnel" was the subject of an address by Irene Mayall of Hamilton General Hospital who based her presentation on the program which has been developed at her own hospital. Miss Mayall pointed out that the quantity and quality of nursing care is directly affected by the health of workers in all categories and that sick employees are a potential source of infection. She was of the opinion, too, that since there is risk in hospital work, i.e., exposure to illnesses it is only reasonable that hospital employees should receive free drugs and medical care. Miss Mayall pointed out that while it does cost money to operate such a service much of the cost is offset by the fact that early treatment of illness decreases very markedly the number of days lost on this account. Moreover when this service is free, employees usually report promptly when ill, she said. Miss Mayall drew attention to the absentee reports issued by the health office to enable the various departments to adjust their time schedules and outlined in detail the preventive measures adopted to control the spread of infections.

Edith G. Young, director of nursing at Ottawa Civic Hospital, whose paper was presented in her absence, urged the importance of in-service education in keeping nursing personnel abreast of the continuous change in medicine and nursing. Providing the most up-to-date knowledge of techniques, it assists in maintaining and improving standards of nursing care. Such a program, she said, "assists in discovering and developing potential leaders, as a result of participation in group discussions . . . better interpersonal relations are achieved and, through more skillful management of human resources . . . better patient care is achieved."

There is at present wide variety in in-service programs, according to Miss Young, and too often they are geared for the improved teaching of students or centered upon technical knowledge solely. The main objective, she said, must be better patient care and, to this end, such a program should provide a medium for the growth of people as individuals, as participating members of the group co-operating with all other departmental groups, and as acceptable members of the community.—*J. F.*

Trustees' Section

PUBLIC relations was the topic on which the session held by the trustees' section of the O.H.A. convention opened. David T. Riddell, of the American Hospital Association, spoke on the rôle of trustees as stimulators for a public relations program. The program need not be expensive or elaborate; important resources lie right within the hospital walls, for, "public relations is essentially good, enlightened management". It is doing good and letting others know about it, and it can not be separated from patient care. Public relations are human relations. There must be co-operation and sharing with the other groups and institutions in

(continued on page 68)

With the Auxiliaries

B.C. Auxiliaries Convene

"God has no end of material
For prophets, priests, and kings—
But what He needs is volunteers
To do the little things."

With this verse as its theme, the 13th annual convention of the hospital auxiliaries of British Columbia met in Hotel Vancouver, Vancouver, on October 16th, 17th, and 18th, to coincide with the annual convention of the B.C. Hospitals Association. In opening the hospital convention the Hon. Eric Martin, Minister of Health and Welfare, said, "The ladies' auxiliaries of the hospitals are doing a work which is of priceless value. Perhaps they don't realize to the full extent their value . . . I am sure I join with all of you in extending to the ladies' auxiliaries of the hospitals of this province our heartfelt thanks on the very wonderful work they are doing."

Over 100 members and friends attended the sessions of the Auxiliaries Division, and 80 of the 100 auxiliaries responded to the roll call. After the introduction of new resolutions to be considered, the ladies were given an explanatory talk by Mrs. R. E. Fitzpatrick on "The Canadian National Institute for the Blind and the Service it Renders". This was in preparation for the tour of the C.N.I.B. and Queen Elizabeth Hall, residence for the blind, which they enjoyed that afternoon. The meeting then separated into four groups according to the size of the hospital served, to hear delegates' reports. This practice was instituted last year and found to be most acceptable. A secretary for each group summarized the reports to present them later to the entire body for discussion. As usual in such a session, many new ideas were gleaned for fund-raising, membership drives, and personal service.

"Buzz Sessions" on the value of thrift shops as a means of fund-raising proved most interesting. Examples given by the smaller towns such as Terrace, Abbotsford, and White Rock were outstanding.

The highlight of the convention was undoubtedly the panel discussion on "The Function of a Hospital Auxiliary". The chairman of the panel was Mrs. Leslie Macdonell of Victoria. Mary Richmond, director of nursing for Royal Jubilee Hospital, Victoria, gave the nurses' viewpoint, while Sister Mary Angelus, superior and administrator of St. Joseph's Hospital, Victoria, presented the ideas of an administrator, and Verna Beek, president of Gorge Road Hospital Auxiliary, Victoria, upheld the standpoint of the auxiliary member. It was interesting to note that all three panellists stressed the importance of working for better relations between the public and hospitals. In summing up, Mrs. Macdonell pointed out that the ladies of the auxiliary

(1) should strive to develop good patient morale;

(2) should be able to interpret hospital services to communities;

(3) must continue to raise funds — for the welfare of the patient;

(4) must strive for good organization, co-ordination, and leadership;

(5) must have faith in what they are trying to accomplish, and remember the reason for being there;

(6) should know the full story of their hospital and its background, and suggest the appointment of an auxiliary historian;

(7) should remember that the function of a hospital auxiliary is that of a service group—never a pressure group.

Mrs. C. S. Stigings
Newly-elected president

On the social side, 125 attended the annual luncheon at the Y.W.C.A. The speaker, Dr. J. F. McCreary, director of the Health Centre for Children, Vancouver General Hospital, and professor of paediatrics at U.B.C., illustrated his topic, "Child Health in India", with coloured slides. During a visit to Children's Hospital, tea was served and Erma Erskine, R.N., director of volunteers at the hospital, explained the function of a hospital volunteer.

The closing session was given to annual reports and the election of new officers. The following members form the new executive of the Auxiliaries' Division, B.C.H.A.: *president*, Mrs. C. S. Stigings, Vancouver; *1st vice-president*, Mrs. A. J. Tripp, Vancouver; *2nd vice-president*, Mrs. C. W. McBey, Trail; *secretary*, Mrs. J. P. Baker, White Rock; *treasurer*, Mrs. L. F. Knight, Prince George; *publicity officer*, Mrs. Leslie Macdonell, Victoria.—*reported by Sue Sturrock.*

* * *

The Dutch Oven

The Dutch Oven, a cook book of traditional Lunenburg recipes, already has raised more than $26,000—enough to build and furnish a nurses' residence for the Fishermen's Memorial Hospital, at Lunenburg, N.S. The Ladies' Auxiliary of the Lunenburg Hospital Society had printed traditional German recipes for everything from raspberry vinegar to oyster stew in the handwriting of the donor. Tourists have spread their fame. The ladies plan to continue publishing the book, now in its fifth printing, as long as it is being sold.

Busy Bees

A double ward in the new home for senior citizens in Yorkton, Sas-

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Cholesterol in the Diet

C. C. Lucas, M.D.,
Charles H. Best Institute,
Toronto, Ont.

THE problem of cholesterol has many perplexing aspects. Unfortunately, a number of uncritical opinions and unwarranted generalizations have led to contradictions and general obscurity on this subject. Part of the reason for this is that much of the knowledge of nutrition has been determined by feeding trials done on small animals rather than on human beings. Even when an autopsy is performed we can't be sure that the dietary procedures have caused the condition observed, since many other factors enter in.

A diet that is of great interest these days is one that will help eliminate the danger of a heart attack or stroke caused by the plugging or bursting of an important blood vessel. Most patients suffering vascular accidents have an increased concentration of cholesterol esters in the blood serum, although some scientists think that certain lipoproteins are more dangerous components of the blood serum.

Sometimes the blood serum cholesterol is three to five times higher than normal, and deposits of cholesterol form in the skin, tendons, and elsewhere. This is apparently an inherited error of metabolism. However, there is very little doubt that man's diet has a strong influence on the concentration of cholesterol in his blood, although it is debatable as to how much, and in what way diet actually affects the degenerative change in the walls of the blood vessels, which leads to fatty deposits and eventual blood clots.

Degenerative changes occur with increasing frequency today, especially in Canada and the United States, and this increase is related to the higher standard of living. Diets high in calories are nearly always high in fat, and observations seem to link dietary intakes of cholesterol with blood cholesterol levels, and with the incidence of atherosclerosis.

Katz and Stember of Chicago, from their experiments on rabbits and chickens, think the evidence they found of dietary cholesterol as a main causative factor is convincing. However, the rabbit is an herbiverous animal, normally ingesting no cholesterol. Further, the amount of cholesterol used to produce the lesion in rabbits is tremendous—ten to thirty times the content of the average Canadian diet. Studies of patients given large daily doses of cholesterol for prolonged periods failed to reveal any significant increase in blood cholesterol level. The increase in blood cholesterol level after eating egg yolk seems to be the result of the fat content, since crystalline cholesterol failed to produce the same effect. The bulk of cholesterol in the body arises by synthesis within the body.

Dietary fat seems to be implicated rather than cholesterol. Observations in Minnesota by Ancel Keys, and in Spain, Italy, and Scandinavia support this. Wilmot and Shank showed that the serum cholesterol of human subjects could be lowered by reducing the fat conent of the diet. Marked changes in plasma lipids can result from relatively short periods of altered dietary regimen.

Approximately 45 per cent of all deaths in the United States result from atherosclerosis. It used to be considered an incurable sequence to aging, but now that it is recognized as a disease it is hoped that it is preventable, and possibly even curable.

This is a situation where all the pertinent facts are not amassed and conclusions are based on a few facts and much guesswork, so that bias and bigotry colour the discussion.

Dr. Albert Lansing points out two very popular misconceptions about atherosclerosis: (1) that it is a disease peculiar to over-fed, over-ambitious, white, male executive and professional men in the U.S.A., and (2) that it is a disease of cholesterol metabolism in which the artery wall plays only a passive rôle.

This is not a new disease. Egyptian mummies 3,000 years old show signs of the disease. Some groups such as the Bantus, Siamese, and Chinese do not seem to suffer from it at all, but it may just be that they don't live long enough to develop the disease. Also the vessel wall is not passive, since other factors may make it more sensitive.

The rôle of the non-lipid portion of the diet is less well known than that of the lipids. Scientists are now studying the modifying effects of type and amount of dietary carbohydrate.

The most serious complications of the disease are from blockage of the arteries, which results in anoxia and starvation of vital tissues. The material causing the occlusion is a lipid, plus a fibrous tissue in a blood clot. It is still not known why or how this lesion starts to form. Dr. Lansing claims it occurs after the breakdown of elastic fibers in the underlying media. Dr. Russel Holman believes it starts as a fatty streak in certain regions of certain arteries. These streaks have been found in children as well as adults; nor is their size and frequency related to the disease that kills the child. They are also found in apparently healthy children killed in accidents. Later, these streaks may acquire fibrinous accreta and more lipid and calcium salts; the length of time apparently depending on the diet. Researchers in England found no increase in the number of these fatty streaks in the last few years, and yet coronary disease is much increased. The question is why? Is it due to different methods of food processing, the hydrogenation of vegetable oils, sedentary living, or nervous tension? It may be the total caloric intake that's important.

Certain unsaturated oils of vegetable origin may lower the blood cholesterol level, while more saturated fats of animal origin tend to raise the level. The esterification of cholesterol in the lumen of the intestine takes place more rapidly with unsaturated fatty acids.

Professor Hugh Sinclair of Oxford attributes the changes in chol-

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From a paper given at the dietetic section of the Ontario Hospital Association Convention, October 1957.

Food Service

sponsored by the

Canadian Dietetic Association

You Were Asking . . .

Several administrators of hospitals of various sizes across Canada were asked the following question: *What commodities and services does your hospital purchase by tender?* Some of the answers received are as follows. Others will appear in our next issue.—*Edit.*

Prince County Hospital, Summerside, P.E.I.

OUR hospital, since it is located on an isolated island in the ocean area, and being entirely dependent upon voluntary, philanthropic contributions for all capital construction or equipment and for funds to meet operating deficits, must seriously consider purchasing in relation to fund raising policies.

Specifically, under the heading of fuel, Bunker C oil is purchased by annual contract, at present from the only supplier prepared to tender. Coal, for our chronic care unit, is purchased by tender, twice yearly. These tenders are requested by letter and are opened and accepted at board of trustee level.

An oxygen contract is signed with one supplier; the limitation date is indefinite.

All our insurance is handled by one general agent, who purchases from recognized local agents on a *pro ratio* basis. This general agent discusses all insurance coverages with the administrator at least twice yearly, and changes in policy coverages are approved by the board of trustees.

All other supplies or services are purchased, on approval of the administrator, by one person, called the "Stores and Purchasing Clerk". A budget for expenditures is approved by the board of trustees and regularly checked, as to monthly purchases, by the finance committee.

The purchasing clerk, in cooperation with the dietitian, places all orders for dietary supplies and keeps in almost daily contact, usually by telephone, with three wholesale grocer firms, placing orders at his discretion after obtaining price quotations. Bread is purchased from the one local wholesale baker. Dairy products are purchased from three local dairies on a percentage basis and at an agreed price. All prices are below those applicable to retail outlets. Linen, housekeeping, business office supplies, routine medical surgical supplies, and new equipment are requisitioned by the appropriate supervisor or department head to the purchasing clerk who places orders in consideration of quality, price and delivery conditions.

Beef is purchased, through the town-owned-and-operated abattoir, from authorized cattle dealers at current market prices.

The establishment of a store and purchasing department, and centralization of all purchasing involved a drastic change from the methods previously used. Its success was dependent upon the ability of the purchasing clerk to work with and satisfy people, together with a keen knowledge of market conditions.

The public relations phase of the change to centralized purchasing certainly required the full co-operation of all members of the board of trustees, senior nursing supervisors, and last but not least, our local suppliers. — *John E. Ledgerwood, Administrator.*

* * *

Welland County General Hospital, Welland, Ont.

IN our hospital we use two methods of tendering. It has been the practice to advertise for tenders on coal supply for one year—a method we have found satisfactory. Tenders are opened by the chairman of the management committee, superintendent, and secretary-treasurer, and then are recommended to the board for approval.

As a general rule, quotations are called for by letter from various dealers on goods and services. It is the policy of our hospital to purchase locally when possible, provided the quality, delivery, price and services are competitive. We feel that as our hospital is supported by local people, this is the most equitable method. If a considerable amount is involved, or if the item is charged to the capital account, the purchase is recommended by the superintendent to the board committee concerned—management or property committee, for approval. The committee then recommends the purchase to the board at the regular monthly meeting. Ordinary smaller purchases or emergency purchases are approved by the superintendent.

Our insurance is carried by a group of local insurance agents, who distribute the policies in a mutually agreeable manner. The insurance coverage is reviewed periodically by the superintendent and the chairman of the property committee, along with the representative of the insurance group.

As our work is done in committee, generally speaking, the committee makes one final recommendation to the board on capital items and large amounts. This recommendation is given careful consideration and is generally approved without prolonged discussion. This is possible because of the confidence the board has in the committee members delegated to study the various problems. Requests for surgical and medical equipment arise as recommendations from the medical staff.—*Jackson R. Bryan, Superintendent.*

* * *

Nanaimo General Hospital, Nanaimo, B.C.

AT our hospital we strongly believe in the principle of buying commodities and services by tender. At the present time we purchase meat on a monthly tender; bread, milk, coarse paper products, and fish, on a six months tender; linen and coal on an annual tender; and oxygen on a five year tender. We also purchase all our insurance by tender, based on the terms of the policies of the different classes of insurance.

We find that the advantages to be gained from buying supplies by tender are that the quality of the goods is assured, and that the financial saving to the hospital is considerable. Of course, it is essential, in order to obtain the quality of goods you require, that carefully worded specification sheets covering each item must be prepared by the hospital for the use of suppliers who tender. We do not advertise for tenders, but send specification sheets with an invitation to tender to principal suppliers of the products. For example, we invite, and usually receive, tenders for coarse paper products from ten suppliers.

The tenders are opened in committee, are dated, and signed by the administrator, and one other

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Packed in order of use—This new pre-pack is put up so the patient gets her supplies in the order of use. Opening the bag, the patient draws out first the four cotton balls for perineal cleansing. Then the napkin, carefully folded to protect its sterility. And directions for patient's use are printed right on the bag.

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Book Reviews

PREVENTION OF CHRONIC ILLNESS by the Commission on Chronic Illness. Published for the Commonwealth Fund by the Harvard University Press, Cambridge, Mass. Published in Canada by S. J. Reginald Saunders and Company Limited, Toronto, Ont. Pp. 338. Price $6.60.

This volume is the first of a series of four on the subject of chronic illness and is based on the work of a national voluntary group. the Commission on Chronic Illness, which studied the problem in the United States from 1949 to 1956.

Part I of this volume presents 21 conclusions and recommendations concerning prevention. The supporting text draws upon the commission's many activities, and explores the questions of effective organizational patterns in administration as well as considers the methods of moving the public to adopt and support preventive measures.

Part II is a series of summaries on the preventive aspects of most of the major chronic diseases and impairments as well as a consideration of the most important factors which contribute to them. A very adequate bibliography follows most of the summaries.

This book presents a compendium of information which would be most useful to those in education and those actively working with problems of chronic illness or engaged in research in the field.

COST FINDING FOR HOSPITALS. Published by the American Hospital Association through its Committee on Accounting and Business Practices, 18 East Division Street, Chicago, Ill., 1957. Pp. 136. Price $3.00.

This third, and latest, manual put out by the American Hospital Association on the general subject of financial management is designed especially to assist hospital administrators in approaching the whole problem of the nature and use of expense data, rather than only the mechanical procedure of cost apportionment.

The reasons for using cost information, as well as a description of the different methods of organizing cost data to meet the specific needs of the hospital are both presented in an efficient manner. These subjects, along with cost studies and hospital budgeting procedures, make this volume a valuable addition to any library of financial management publications.

SILENT SPOKESMAN, an aid to the speechless by Wayland W. Lessing. Published by Hospital Topics Magazine, Chicago, Illinois. Illustrated. Pp. 35. Price $1.50.

This book is a working tool for the speech-handicapped. Designed to relieve anxieties caused by inability to communicate, it eliminates everyday issues before they become disproportionately significant. The speech-restricted person need only point to an illustration of what concerns him.

The procedure recommended for using the book is one of deduction based on eliminative questions and answers. The text begins with illustrations of basic necessities, progressing to broader grouping and concepts. When the patient has localized his realm of thought, it is not difficult to discover what he wants by questions to which he can answer "yes" or "no".

Special consideration has been given to possible physical limitations—bold type for poor eyesight, widely spaced text for easier pointing, durable pages for uncoordinated hands.

Speech therapists can use this book as a speech rehabilitation manual. It could also be a word-association guide for teaching children, or, in hospitals, a common denominator for interpretation when language differences prevent communication.

This little book is a language-substitute.

The exercise of writing is an indispensable part of any genuine effort towards mental efficiency.—*Arnold Bennett.*

Alberta Convention

(concluded from page 45)

neglected, and those communities which, recognizing the need, have embarked upon a program of rehabilitation should be encouraged and assisted in the provision of those facilities essential to the rehabilitation of these patients,

WHEREAS Associated Hospitals of Alberta recognizes that active treatment hospitals cannot provide such treatment as speech therapy, vocational therapy and physical therapy which, if long continued, can result in transforming a bedridden patient into an active member of the community;

THEREFORE BE IT RESOLVED that Associated Hospitals of Alberta ask the provincial Department of Health to take such steps as will result in the co-ordinating and widening of efforts presently being made for the rehabilitation of patients suffering from long term illnesses.

Definition of "the local doctor"

WHEREAS under the present Provincial Municipal Hospitalization Plan Regulations Section 1 (c) referrals of cases are authorized to be made by "the local doctor" with the approval in writing of the local authority, but no definition is given for the words "local doctor", and,

WHEREAS by some authorities the word "doctor" is held to include optometrists, dentists, chiropractors and others, and whereas the expense of a law suit against a municipal hospital by an individual known as "doctor" and not being in fact a medical doctor is to be avoided,

THEREFORE BE IT RESOLVED that the Division of Hospital and Medical Services of the Department of Health be requested to secure an Order-in-Council precisely defining the term "local doctor" in the said regulations.

Exclusion List of Drugs

WHEREAS there has been considerable lapse of time since the last revision of the list of drugs, et cetera, exclusions (commonly known as Appendix A) under the provincial hospitalization plan,

WHEREAS during that period of time many new and expensive drugs have been placed on the market and are being prescribed by doctors, and whereas many of these new drugs should be placed on the exclusion list,

THEREFORE BE IT RESOLVED that the Department of Public Health be requested to revise the present list of exclusions without further delay, and in future to make revisions of the list semi-annually.

Officers Elected

Hon. president, Hon. Dr. J. D. Ross, Minister of Health; *immediate past-president,* S. V. Pryce, Calgary; *president,* Chief Judge N. V. Buchanan, Edmonton; *vice-president,* Dr. Howard P. Wright, Calgary.

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Manitoba

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all assistance it can give him in the future, and that we do assure him that this association is ever ready to co-operate with him and his department in giving such advice and assistance as is within its power to give.

1. WHEREAS the Canadian Hospital Association has made representation to the Government of Canada recommending that

(a) the hospital construction grants program be continued for a further period of five years from April 1st, 1958, and

(b) that the scope of the grants be broadened in order that a construction project involving any hospital department or hospital residence accommodations may become eligible for grant assistance, and

(c) that the formulae upon which the grants are calculated be modified, and the amounts provided be increased so that the contribution by the Government of Canada to each hospital's construction project should equal approximately one-third of the total cost;

AND WHEREAS the Associated Hospitals of Manitoba is aware of the necessity of modernizing and replacing old facilities as well as expanding new hospital facilities to meet the growing public need for adequate hospital services in the province of Manitoba,

AND WHEREAS the hospital construction grants program has limitations that tend to restrict the best development of hospital facilities,

THEREFORE BE IT RESOLVED that the Associated Hospitals of Manitoba endorse the representation made by the Canadian Hospital Association to the Government of Canada,

AND BE IT FURTHER RESOLVED that the Associated Hospitals of Manitoba urge the Manitoba government to adopt a similar assistance program for the construction and modernization of hospital facilities in Manitoba.

2. WHEREAS the Associated Hospitals of Manitoba did, in May, 1957, submit to the Minister of Health and Public Welfare a brief setting out the position of the association on the introduction and management of a governmental plan for hospital care insurance,

THEREFORE BE IT RESOLVED that the Associated Hospitals of Manitoba in convention assembled endorse the views expressed in this brief, and urge the Manitoba government to consider them carefully.

3. WHEREAS the Associated Hospitals of Manitoba in the annual meeting, October 19, 1955, passed the following resolution:

"WHEREAS hospitals' schools for the preparation of registered nurses are operated by funds obtained through charges levied against and collected from patients in the Manitoba hospitals conducting schools of nursing,

AND WHEREAS schools of nursing do not receive governmental financial assistance or support for this educational activity as do other institutions of learning,

THEREFORE BE IT RESOLVED that the Associated Hospitals of Manitoba urge that the Manitoba government recognize the teaching and training of nurses and other personnel now conducted by hospitals as comparable in importance to education provided by other schools of learning, and therefore as eligible for comparable financial assistance."

THEREFORE BE IT RESOLVED that the Associated Hospitals of Manitoba re-affirm its position in this connection, and that this resolution again go forward.

4. WHEREAS the Associated Hospitals of Manitoba did appoint a Joint Committee on Nursing, in co-operation with other interested groups,

AND WHEREAS its early studies have pointed out several areas in which concrete steps can be taken to alleviate the nursing shortage,

THEREFORE BE IT RESOLVED that the Manitoba government be requested to take the following early steps:

(a) To increase the fund available for vocational grants to needy students on entering or presently within hospital schools of nursing.

(b) To increase the recruiting and enrollment of the training program for L.P.N.'s.

(c) To expand and diversify the program of graduate education of the profession of nursing at the University of Manitoba.

5. BE IT RESOLVED that the feasibility of Workmen's Compensation Insurance coverage for all hospital employees be investigated by the incoming board of directors, and proper steps be taken, if advisable, to implement such a program.

6. BE IT RESOLVED that the Associated Hospitals of Manitoba wish to record appreciation to the speakers who have contributed so much to the success of this meeting, to the exhibitors whose displays have added greatly to the information and interest of delegates, to the manager and staff of the Royal Alexandra Hotel for their excellent arrangements, to the press, whose reporters have been in attendance each day, and to the nine organizations participating with the Associated Hospitals of Manitoba in this conference.

7. BE IT RESOLVED that the members of the Associated Hospitals of Manitoba wish to express their appreciation of the efforts of the officers and directors on behalf of the association during the past year,

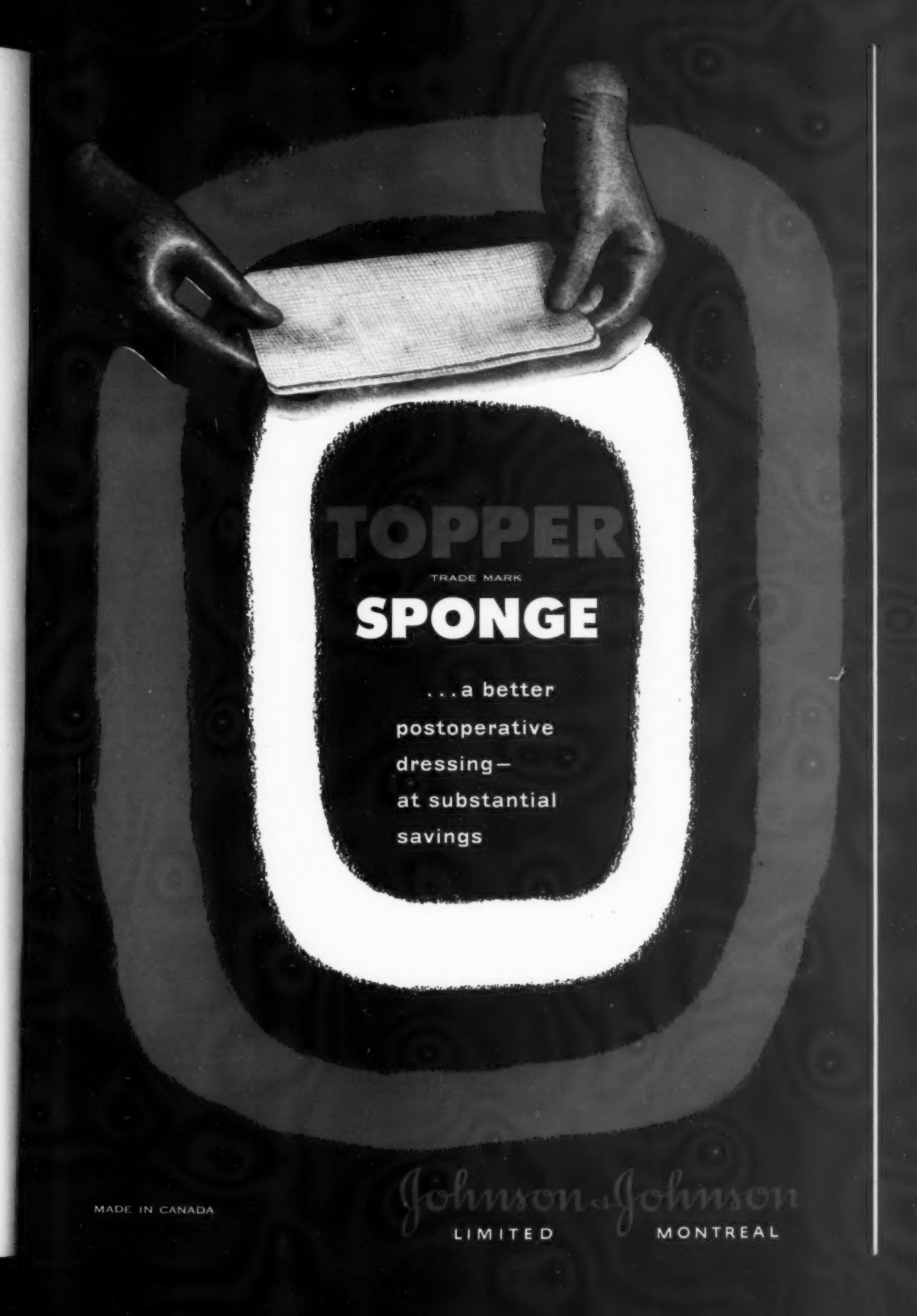
AND BE IT FURTHER RESOLVED that we, the members, concur and approve all actions of the board of directors in the conduct of the business of the corporation since the last annual meeting.

Twenty Years Ago

(The "Canadian Hospital", December, 1937)

Group Hospitalization

This movement is progressing with ever increasing momentum. New York City now has over 500,000 members and St. Paul has over 100,000. Canadian plans have not been nearly so spectacular in their growth inasmuch as most are in smaller centres. However, the city-wide plan in Edmonton is growing steadily and now has some 5,500 members. Kamloops, B.C., now covers approximately 6,000 people and the plan at Kingston nearly 2,000. The latest one to be started in Canada is the joint plan of the two hospitals in Moncton, N.B. A plan is being started among the rural hospitals in the area north of Edmonton. In Toronto the plans for a group plan have been suspended in view of the development of what is called the "Associated Medical Services, Inc.", a non-profit, medico-lay organization operating in close co-operation with the Ontario Medical Association and the Toronto Academy of Medicine, and providing coverage in several Ontario centres for general practitioner, specialist and (in part) hospital accounts. This body is not starting out with any great splash, but is enrolling its membership upon a sound, carefully worked out basis.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(continued from page 53)

the community. Enthusiasm, initiative, and devotion must be earned; they can never be bought. The personality of the hospital, which Mr. Riddell feels is very "real", must be analyzed, developed and nurtured. The board of trustees must be prepared to accept its share of the responsibility for this task.

Under the heading, "Collective Bargaining Agreements in Hospitals", Colonel Walter L. McGregor, member of the Board of Governors, Metropolitan General Hospital, Windsor, discussed some of the contentious issues which are subjects of dispute at hospital union bargaining sessions. These included probationary periods, sick leave, weekend and offshift work premiums, hours of work, statutory holidays and vacations with pay, wage demands and overtime pay.

He stressed the importance of adequate preparation before bargaining. The issue must be clearly defined and evaluated. All pertinent information must be collected and understood, and helpful statistics must be accumulated. He warned against generalization, stating that provisions negotiated into contracts in large, urban hospitals will, in most cases, be inappropriate for smaller, rural hospitals.

To ensure adequate patient care, it is essential that in non-unionized as well as unionized hospitals, trustee boards follow the trends in union demands and agreements and, when practical and necessary, make adjustments in the wage structure and working conditions.

Dr. Malcolm G. Taylor, associate professor of political economy at the University of Toronto, stated that the new hospital insurance plan will in no way affect the legal status of Ontario's hospitals. "The hospitals will remain as they have in the past, namely a privately owned or municipally owned enterprise, voluntary, and independent, self-governing and autonomous".

Dr. Taylor feels that the health scheme is an inevitable development from changes in the nation's economy. The program represents a decision democratically arrived at by the people. While it helps solve some of the present hospital problems such as operating costs, it creates new ones as well. Perhaps the most dramatic will be the increase in use of hospital services by the public. This must be met by a strong, well-organized medical staff qualified to distinguish between need and demand.

Dr. Taylor emphasized that there is a continuing and even greater call for citizen participation. The need for the wisdom, guidance and support of the trustee will be increased rather than diminished. —*M. W.*

Dietetic Section

THE dietetic section of the Ontario Hospital Association met on Tuesday, October 29, for two very interesting sessions. Chairman was Doris Anglin, Wellesley Division, Toronto General Hospital. Greetings were brought to the group by Lois Hurst, of the Hospital for Sick Children, Toronto, on behalf of the Ontario Dietetic Association, and by Mr. C. V. Charters, retiring president of the O.H.A.

The first speaker was Dr. C. C. Lucas, a food chemist from the Charles H. Best Institute, Toronto. His topic, "The Problem of Cholesterol in the Diet", was received with much interest, since it is not definitely known whether the intake of dietary cholesterol is related to the incidence of atherosclerosis (see page 55.)

The panel on "Nutrition Education" was chaired by Helen Hood of the Toronto General Hospital. W. J. Quinn of the Toronto Board of Education reviewed what the Toronto public schools are doing in this respect—the city nutritionist runs courses for teachers and visits classes, stressing good food habits. School cafeterias plan their menus around Canada's Food Rules and students at six special health schools are given a free, nutritious meal once a day.

The public health nurse also works closely with the teachers, according to Elizabeth Fletcher, a district supervisor for the Department of Health. The co-operation of the parents is most important and, she added, the new home-makers, especially those attending prenatal classes, are the most receptive to new ideas. On her home visits the public health nurse also has a good chance to help with marketing, budgeting and food preparation.

Dr. Wesley Dunn of the Royal College of Dental Surgeons of Ontario described the preventive dental program of the dental public health officers. One pamphlet, "Hidden Sugars", stresses the nutritional aspect of the problem of dental caries.

The hospital can provide a continual demonstration of Canada's Food Rules and teaching can be done through the out-patient department, by lectures to medical interns, courses for student nurses, and by attractive, nutritious meals for hospital employees.

The extension division of the Department of Agriculture is sponsoring two-day courses for leaders from approximately 250 organizations throughout the province. Frances Hucks of this department expressed the hope that they will go back from this course to contact about 5,000 home-makers in their communities.

Dr. A. H. Squires of Wellesley Hospital had as his topic, "Psychosomatic Medicine and Its Dietary Manifestations". He stated that emotions have a great effect on the digestive system, some speeding up secretions, some slowing them down. People who are overweight or underweight may be so as a result of psychological factors and often they cannot be helped with a rigid diet. A high caloric diet for an emaciated patient may cause a great deal of psychological harm, as a huge pile of food may be worse than none at all. A small portion, if it encourages him to eat, would be better in such a case.

The afternoon session opened with a report by Helen Goodrow, Canada Bread Co., Cornwall, of her experiences as a nutritionist in the Canadian Red Cross refugee camp for Hungarians in Vienna. Austria was just getting back on its feet from the Allied Occupation when the refugees started pouring in. Miss Goodrow's camp was 15 miles from the border and had room for nearly 1,000 people in its cold, solid concrete buildings. There were only two home-sized stoves and no hot water except what could be boiled on these stoves, but the greatest problem was the language barrier. Rations were very basic as they were allowed only ten cents per person per day, supplemented by donations from all over the world. This meant that the menu varied according to the donations available. Christmas dinner, for instance, consisted of soup weiner schnitzl, rice, a torte, and bananas. No citrus or other fruit was available except one apple a day. Miss Goodrow came back with every sympathy for the struggle of the new Canadian to learn a new language.

W. C. Jones, staff psychologist of the Ontario Hydro Commission, discussed "Human Relations". This topic has become of interest in the last half-century with its growth of

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industrialization. The personal sense of satisfaction with the work effort disappears on a production line, he stated. Studies made on the effect of certain factors on production found that any change, even restoring the original conditions, increased production because the workers, knowing they were being studied, felt more important. When supervision was relaxed the worker felt more mature and produced more. The recognition of a worker's ability should produce good motivation for the worker. Praise usually produces more results than punishment; an attitude of trust is much more successful than one of suspicion. Giving democratic, rather than authoritative, leadership involves a sensitivity to the feelings of others, tolerance, and the ability to listen to problems in order to get a better insight into the person's feelings. Production is highest when the supervisor is concerned with the workers' welfare, rather than production. It is best to see the workers as people in their own right.—*Wilda Hurst.*

Accounting

DELEGATES were welcomed by S. G. Anderson of Ottawa Civic Hospital, who presided over the meeting of the accounting section. In the secretary's report on the year's activities, Ocean G. Smith referred particularly to the bi-monthly *Accounting Bulletin*, to the cost studies made on hospitals, and to the year's progress in developing a system and forms for budgeting.

The inclusive rate system recommended by the Associated Hospitals of Manitoba and put into effect by every hospital in that province on April 1, 1957, was reported by C. K. Temple, of Children's Hospital, Winnipeg, to be successful beyond expectations.

After careful study of various modifications of an inclusive rate structure, said Mr. Temple, the Manitoba association recommended the adoption of inclusive rates for all in-patient care, and for out-patient care in organized out-patient departments, and the continuation of the current system of charging for services supplied to private referral out-patients. The new system, accompanied by an intensive public relations program, has received no criticism from the public.

Part of this success, Mr. Temple felt, can be attributed to a carefully prepared budget system which was almost impossible under the old rate structure. Several concrete advantages have been the effect of the new system on Mr. Temple's own hospital. Due to the simplified posting and billing procedures, they were able to increase accommodation from 115 to 190 beds without adding to the staff of the business office. Problems of late charges have been eliminated; the preparation of the budget has been simplified; and, most important of all, patients are assured adequate diagnostic and medical facilities without excessive financial worries.

Cecil Garry, Assistant Medical Aid Officer of the Workmen's Compensation Board of Ontario, reviewed recent changes in the Board's policy concerning payments to hospitals. For a lively question-and-answer discussion of problems in handling these accounts, Mr. Garry was joined by E. P. McGavin and O. G. Smith, of Toronto; C. K. Temple, Winnipeg; D. D. Thornton, Port Colborne; C. K. Wright, Oshawa; and S. G. Anderson who presided over the panel.

Elected to the accounting section committee for 1958 were; S. G. Anderson, Ottawa Civic Hospital; A. S. Brown, Toronto East General Hospital; L. J. Campbell, Toronto General Hospital; J. B. McAulay, Toronto Western Hospital; J. D. Snedden, Hospital for Sick Children, Toronto; J. Stewart, Hamilton General Hospital; D. D. Thornton, Port Colborne General Hospital; J. T. Walker, Atikokan General Hospital; C. K. Wright, Oshawa General Hospital; and Sister Marie Joseph, Representative of the Catholic Hospital Conference.—*M.W.R.*

Laundry Section

THAT the members of the laundry section of the Ontario Hospital Association heartily approved of their recently-formed organization was shown by the enthusiasm pervading their second annual meeting at this year's O.H.A. convention.

Presiding was A. E. Rudd, laundry manager of the Royal York Hotel, Toronto, who expressed his appreciation of the group's active interest in their section. He also mentioned his hope that a provincial board to give advice on laundry management might be set up.

C. V. Charters, president of the O.H.A. 1956-57, greeted the section and welcomed them to the convention as an integral part of the association's body.

S. Hierons of Kitchener-Waterloo Hospital gave a brief explanation of the first school for training institutional laundry personnel—a highly successful experiment held at the Ontario Agricultural College in Guelph last summer. The instruction in classification, wash room procedures, equipment and maintenance, lay-out, job training, textiles, and personnel relations had been of such practical value to the 25 students taking the course, that Mr. Hierons hopes the school will continue to be held each summer.

The advantages of a modern laundry plant were discussed by Brock H. Payne, administrator of the Brantford General Hospital. Mr. Payne described his hospital's old laundry department as out-dated, cramped and costly. He then told how a complete reorganization, which involved a new lay-out and modern equipment, changed not only the appearance and staff working conditions, but the efficiency and economics of the whole laundry operation.

Before the meeting adjourned, members were invited to discuss their particular hospital laundry and linen problems with the panel of "experts" up front. No one was shy in coming forward to ask questions—whether about production or about bleaching methods. A. T. George, Hamilton General Hospital; L. A. Kusluski, St. Joseph's Hospital, Toronto; H. W. Shea, Toronto General Hospital; Brock H. Payne, and A. Cornelson, both of Brantford General Hospital; S. Hierons, Kitchener-Waterloo Hospital; and W. Pennington, Victoria Hospital, London, ably answered all the queries put to them.—*H.E.G.*

Pharmacists' Section

THE pharmacists' section of the Ontario Hospital Association Convention opened with greetings from the president, Phyllis Takenaka. In her report, Miss Takenaka stressed the need for more activity by the Ontario Branch of the Canadian Society of Hospital Pharmacists, and the need for the branch to take its full share of responsibility in the affairs of the national society.

Irene Kostuk, Northwestern General Hospital, Toronto, gave the secretary's report, in which she outlined the activities of the Ontario Branch for 1957. Dora Grobb of Toronto Western Hospital presented the treasurer's report.

John Haslehurst, pharmacist,

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Provincial Notes

Newfoundland

Two employees at Pepperrell Base Hospital have received cash awards for "Sustained Superior Performance". Several awards were also given for beneficial suggestions.

The Carbonear Red Cross Community Hospital was opened in October. The administration of the hospital was set up by Mrs. Peter Freer, who studied hospital management on a Red Cross scholarship.

Prince Edward Island

An expansion program costing $1,300,000 is to be commenced by the Prince Edward Island Hospital next spring, it was announced by the board of trustees. The hospital bed space will be increased by 64, by a four-storey annex, bringing the total capacity to 259. Ratification of the national hospitalization scheme called for complete revision of the original plans.

Nova Scotia

The Queens General Hospital in Liverpool is receiving $3,322 as a bequest of the late Janet E. Mullins. Part of the money will be used to furnish and maintain a room, to be called the Janet Mullins Memorial Room.

Harbour View Hospital, Sydney Mines, has received full accreditation for a period of three years. Queens General Hospital in Liverpool has been accredited for 12 months.

A new Poison Control Centre has been established at the Children's Hospital in Halifax. Operating on a 24-hour basis, the centre offers information on poisoning by household products, and the equipment for treatment.

New Brunswick

The cornerstone of the new St. Joseph's Hospital in Saint John, has been officially laid. During the ceremony the Kiwanis Club presented a cheque for the furnishing of a children's playroom. The 200-bed hospital, to cost an estimated $3,500,000, is expected to be in use by February.

Quebec

Maurice Richard, Montreal Canadien's hockey star, marked the 400th goal of his N.H.L. career with the gift of a bed to the new Ste-Justine Hospital for children.

A fleet of ambulances, manned by hospital staff and volunteer stretcher bearers, convoyed 300 sick children from the old hospital to the new $30,000,000 Ste-Justine Hospital, Montreal. The new hospital, designed to be efficient and functional rather than luxurious, provides 860 beds, and 70 bassinets, 20 operating rooms, and four delivery rooms. The 11-storey school for nurses also serves as a residence for students, and a residence is provided for non-medical personnel.

The first sod has been turned for an extension and nurses' residence at St-Luc's Hospital in Montreal. The new wing, residence, laundry and heating plant, designed by Henri S. Labelle, will cost over $10,000,000. It will increase hospital accommodation by 300 beds.

St-Sacrement Hospital, Quebec City, will spend $1,500,000 to construct an addition. Architect for the seven-storey building is Pierre Rinfret.

Sherbrooke Hospital has received full accreditation in the survey conducted this year by the field representative of the Joint Commission on the Accreditation of Hospitals.

Brownies of the First Knowlton Brownie pack have presented the Brome-Missisquoi-Perkins Hospital at Sweetsburg with a baby feeder, a play table, and a baby walker.

A new $110,000 paediatric department has been opened at St. Mary's Hospital, Montreal. The new department formerly housed student nurses, and is located on the seventh floor of the west wing. It will accommodate 30 patients.

Salaries have been raised at the Hôtel Dieu in Sherbrooke.

Ontario

The original building plan for Ottawa Civic Hospital called for extra stories to be built on top of the existing pathology building. Cost estimates were computed accordingly and authority to borrow was obtained. When a separate seven-storey building was decided on, however, authorization of the Ontario Municipal Board had to be obtained to borrow $1,000,000 more. Now, the contract has been awarded and construction will begin.

The architect's plan for a 33-bed addition to Listowel Memorial Hospital, Listowel, has been approved. The new wing designed by Douglas Kertland will cost an estimated $400,000, but besides increasing the bed capacity, it will provide a new operating room, an obstetrical department and a nursery.

Macdonell Memorial Hospital for long-stay patients is being completely renovated and fireproofed. It was founded in Cornwall sixty years ago by the Religious Hospitallers of St. Joseph. Special facilities for physical, recreational, and occupational therapy will be provided in a new department of the central wing. Fresh colours, better services, transmission of voice and music throughout the hospital will encourage rehabilitation, as well as relieve the presently over-crowded active treatment hospitals.

The new wing of the Owen Sound General and Marine Hospital was officially opened in November by H. M. Jackson, now president of the Ontario Hospital Association. Completion of the wing means that the hospital has 165 beds, four recovery beds, and 33 bassinets. The service facilities are designed to allow for future expansion.

Although the provincial ministers who were to officiate were grounded by fog, a suitable ceremony opened the new 1,200-bed Ontario Hospital in North Bay. The sprawling three-storey hospital contains five independent pavilions, connected by a corridor. The administration building and the nurses' residence for its staff of 400 are both separate structures. North Bay's St. Joseph's Hospital also opened a new wing this fall.

The Dutch Missionary Sisters of the Precious Blood are extending their 20-bed convalescent hospital in Willowdale, Metropolitan Toronto. The addition will cost $600,000.

A quiet service marked the opening and dedication of a chapel

in Kingston General Hospital. It is to be "a place set apart in the heart of the hospital for the hearts of those who will use it".

Two anonymous donors have donated new equipment valued at $15,000 to the South Waterloo unit of the Canadian Cancer Society. Patients in the Galt area need now come only as far as the South Waterloo Memorial Hospital for diagnosis and treatment of surface cancer.

Peterborough's city council has decided to follow the welfare committee's recommendation that the old Queen Mary Isolation hospital be razed. Detailed plans are to be drawn for a 180-bed home for the aged to be erected on the site.

Manitoba

A contract for the erection of a $1,270,000 extension to the Salvation Army's Grace Hospital in Winnipeg has been awarded, and construction will proceed.

Winkler's Bethel Hospital has had to ask all crutch users to return the crutches to the hospital when they no longer need them. Patients in the past have failed to return them.

Rates have been raised at Morris General and Emerson Hospitals, in Morris Hospital District No. 25.

Saskatchewan

Central Butte Union Hospital has received a provincial grant of $12,500 for renovation and extension. The extension will increase the capacity from 18 to 27 beds, and will provide a new operating room, offices, and work rooms.

Kerr and Cullingworth of Prince Albert have been appointed architects for the addition to the District Union Hospital at Yorkton, Sask. Costing an estimated $650,000, the four-storey extension will accommodate about 100 beds, and will contain kitchen facilities.

Alberta

At Tofield Municipal Hospital, the new addition to which was officially opened in October, facilities have been both improved and added. The bed capacity is increased to 30, the nursery and the operating room are renovated and enlarged, and a case room and a labour room are provided in the new wing.

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Cholesterol in the Diet
(concluded from page 55)

esterol metabolism to a loss of essential fatty acids from many foods due to modern food processing such as the introduction of agene to flour and the hydrogenation of vegetable oils.

It is now recognized that some fats do not raise the blood cholesterol level. Butterfats and beef drippings raise it, but olive oil, sunflower seed oil, and corn oil lower it. It has been shown that a vegetable diet lowers the level of serum cholesterol in man, even if the fat content remains high, and corn oil is the most consistently active. These vegetable oils are high in polyunsaturated fatty acids but it is not clear why they have this effect.

Professor Sinclair has suggested that the high levels of cholesterol esters in North Americans may result from a chronic deficiency of essential fatty acids. Perhaps in the absence of adequate highly unsaturated fatty acids, cholesterol is esterified with more saturated fatty acids than normal. If Sinclair is right in claiming that many diets may be deficient in essential fatty acids because of inadequate intakes of arachidonic acid and vitamin B6, the resulting high blood cholesterol levels may be easily prevented, and even curable.

Sinclair has also suggested that the hydrogenation of vegetable oils produces unnatural isomers of essential fatty acids, which might act as antimetabolites but this theory has not been fully tested. Until it is definitely proved that hydrogenated fats are harmful it seems unwise to condemn them. Dr. T. B. Van Itallie of Harvard has said, "Unless such assertions are adequately documented, and they have not been, they serve merely to encourage the food faddists and others who thrive on all reports that tend to discredit civilized diets —until the status of the essential acids in relation to cholesterol metabolism is clarified, no judgment can be made concerning the possible desirability of recommending major changes in the cooking and eating habits of a large segment of the world's population".

There is evidence that many dietary factors are involved in the enigma of atherosclerosis — fat, cholesterol, carbohydrate, protein, sulphur-containing amino acids, choline, pyrodoxine, and possibly others, and also that exercise (or lack of it) and energy balance may be involved as well.

The dietitian cannot yet be given explicit information for designing a curative or even preventive, diet. One fact appears clear. The cholesterol content of the diet seems to be of minor, if of any, significance in controlling the level of cholesterol in human serum. Some animal fats raise the level, some vegetable oils depress it. No drastic alteration in the menus, such as the complete elimination of eggs or bacon or butter, seems indicated, although a reduction of the intake of animal fat to minimum amounts providing palatability and variety may be desirable. Preferential use of vegetable oils in cooking and avoidance of excess calories would appear desirable.

Indeed, gradual reduction of body weight by sparing use of a complete diet seems to be one of the more effective ways of reducing the level of cholesterol in the serum, and presumably of arresting the atheromatous changes characteristic of our era.

H.M. Awards

In the contest for the best annual report, sponsored by the magazine, *Hospital Management*, in 1957, Dr. Leigh J. Crozier of Hermann Hospital, Houston, Texas, was awarded the bronze plaque for hospitals of 401 beds and over. Dr. Crozier, a Canadian, was superintendent of Victoria Hospital, London, Ont., from 1943 to 1949.

The Oakville-Trafalgar Memorial Hospital, Oakville, Ont., received honorable mention in the small hospital category.

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Of Eternal Merit
(continued from page 33)

few financially poor. With Blue Cross and insurance plans and municipal grants, hospitals are paid even for ward service. But, Christ spoke immortal words when He rebuked Judas, "The poor you have always with you". There are poor in our hospitals today and there always will be. It is up to us, and those who will come after us, to recognize them according to the varied circumstances of time and place.

We live in a world that is materialistic in outlook yet Christian in claim. In everyday life we have not too much time for the things of the spirit. We talk about increased church attendance and religious revival, but are such statistics anything more than a population trend? Those without any church affiliation are legion. Religious education lags. Few know the important events in Christ's life, let alone what he taught. How many know any prayer save the "Our Father"; few are able to recite the Ten Commandments by heart. And, therefore, how many are making this life a preparation for another?

Sickness, rendering a person dependent, tends to soften the heart and humble the spirit and if it is serious it brings solemn thoughts about death and judgment. Viewed from a sick-bed, the world seems less substantial and enduring while eternity seems nearer and more real. Here then may be the poor, for "What does it profit a man if he gain the whole world and suffer the loss of his own soul". Certainly there are few times so favourable for helping a person spiritually as when he is ill. Hence the opportunity and the obligation of hospitals of bringing Christ to their patients through their courteous treatment of ministers of religion and through providing the facilities they need. The record in this regard is not universally perfect.

Today we hear a great deal about alcoholism. It is a problem resulting in broken homes, families supported by public funds, absenteeism costing millions in industrial loss, accidents and crime and so on. But whose problem is it? Some hospital people feel that it is a moral aberration and that here sympathy is wasted. Beds are scarce. Such patients cause behaviour problems so they are to be avoided. There is public opinion which says the drunk

should be punished and the hospital helps inflict it by making admission extremely difficult. Here then may be the poor. Alcoholism is a public health problem and health is the hospital's business. It is a disease accompanied by deficiencies and ills that make hospital care essential to rehabilitation. Before religion can do anything spiritually, the hospital must do something physically. Instead of a "hands-off" policy there might be an "open door". A small section set apart and the services of a psychiatrist are all that is required for a start, for then great work can be done by the best of therapists in the field, Alcoholics Anonymous. Convinced as they are that the victims of this disease are worth curing, they wish to serve communities in a task that they cannot effect alone. Could we not share their views on the evidence of their success and share in their practical Christian charity? From their program we know that they have an understanding of spiritual values.

Medical science has added years to life. Today people live longer and this would be a wonderful thing if corresponding advancements had been made in the field of social welfare. But they have not. Hence people live longer to struggle with the handicaps of chronic illness and to endure the infirmities of old age. Basically their needs are just the same as those of anyone else—food, shelter, clothing and medical care, interests that will be stimulating and satisfying, occupations that will give them a feeling of value, and contact with people to whom they are important. We admire the efforts that are being made to give life to the added years, the apartment projects, the Second Mile Clubs, and the modern homes for the aging. But because these facilities are limited many such persons find their way to hospital beds. Here again may be the poor.

We cannot argue against efforts to have them removed to accommodation more suitable and less expensive; but forebearance with such people is necessary and understanding co-operation between our institutions and agencies essential. Deceptive unloading is not unknown and the policy that tolerates it unchristian. The aim of geriatrics is to prolong life not in misery but in comfort. Who then but hospital authorities should be more sympathetic to the problems created?

Definitely then if you look around you will see that other types of poverty have replaced the financial, in your very midst. There are spiritual and emotional and social varieties. We have considered three examples. Make them your concern so that the work which your hospitals are doing may be of greater value here and of eternal merit hereafter.

Involuntary Philanthropist

It is about time that we realize that the situation will not improve even if we ignore it. In many areas, hospital employees' wage levels are still unrealistically low, and consequently lower cost hospitalization is being maintained at the expense of that "involuntary philanthropist", the hospital employee.—*Dr. Albert W. Snoke.*

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Auxiliaries

(continued from page 54)

katchewan, has been furnished by the "Busy Bees" of the Pebble Lake district. D. MacMillan, chairman of Anderson Lodge, accepted this assistance toward the home, which will be opened in December, from Mrs. W. Martel, president of the 25-member organization.

Geraldton Peach Festival

The Geraldton Ladies' Hospital Auxiliary featured a Fur and Fashion Show at their annual peach festival tea. While the furs and fashions were provided by a firm in nearby Fort William, Ont., they were modeled by the ladies of the auxiliary.

Memorial to Pioneer Doctor

On the anniversary of his arrival at the Three Hills Municipal Hospital, in Three Hills, Alta., the Hospital Auxiliary presented a bronze plaque to honour the memory of the late Dr. Thomas Sawdon. The doctor had served the district for 37 years.

TV Set Given to Newfoundland Hospital

A television set, to be used in the women's ward of The Cottage Hospital, Stephenville Crossing, Nfld., was presented to Dr. Dermott Murphy. The gift was made by the local Caribou Club.

Nearly New Shop

The joint project of the ladies' auxiliaries of the Montreal Children's Hospital and the Royal Victoria Hospital in Montreal has been cleaned and reopened for business. Most of the useful articles can be offered at the Nearly New Shop for prices advantageous to thrifty shoppers, but every once in a while something of great value turns up. Right now they have a pair of ancient dynasty Chinese vases being considered by museum authorities.

Possible Pitfalls

The Women's Auxiliary of Brockville General Hospital, Brockville, Ont., heard some pertinent observations on volunteer service from Isobel Laird, M.A., assistant professor of psychology at Queen's University. "Volunteer", once referring to inexperienced soldiers who were thrown from their horses without adequate cause, has had many meanings, and is still variously interpreted. Some people, volunteering for the sake of prestige or self-esteem, may feel that their service entitles them to what they want out of the job. As in the case of giving orphan homes what was left over from banquets, ir-

regular volunteer service actually prolongs the existence of a problem situation. Sometimes hiring someone to do the work would be better for the hospital, the person hired, the volunteer's family, and the volunteer herself.

On the other hand, volunteer service can set up the chain reaction of small details which makes possible the work of great physicians.

Miss Laird remarked that the United Nations organization, the largest voluntary work ever undertaken, first had to call on volunteer agencies. Volunteer police work is playing a vital rôle in juvenile delinquency. Volunteer work in hospitals can aid tremendously toward a patient's recovery.

The volunteer makes her greatest contribution when she gives her services only where they are needed —and gives them regularly.

Theatre Opening Aids Hospital

The Women's Hospital Aid received $433.17 from the official reopening of a local theatre in Owen Sound, Ontario. The contribution will be used to help finance the children's wing in the new Owen Sound General Hospital.

Modern Stretcher

A cheque for the amount of $893 as payment for a special emergency room stretcher was presented to Dean E. Holroyd, chairman of the Lethbridge Municipal Hospital Board, by Mrs. L. T. Allen, past president of the Ladies' Auxiliary. This unusual stretcher is designed primarily for use in serious fracture cases. It has a removable platform and adjustable legs, so that a patient may be moved from the x-ray room to his bed without being taken from the stretcher.

New Machine Ordered

A new $550 BMR machine has been ordered for Salmon Arm General Hospital, Salmon Arm, B.C., by the Girls' Hospital Aid. The B.C.H.I.S. does not pay the usual one-third of the cost of this machine.

For the Building Fund

The Chatham Hospital Aid presented a cheque for $2,000 to the president of the advisory board of Hotel Dieu, Chatham, N.B., to assist their building program.

French Group Donates Equipment

The French section of the Ladies' Auxiliary of the Youville Hospital, Noranda, Que., has purchased an ultra-violet-ray machine along with three ophthalmoscopes for the hospital. The giving of this useful equipment was made possible, said Mrs. Y. Juteau, the president of the auxiliary, through the generous returns from their tag-day appeal.

Oxygen Analyzer

The games-month receipts of Tillsonburg Hospital Auxiliary, Tillsonburg, Ont., has purchased an oxygen analyzer to be used in administering oxygen to babies.

White Rock, B.C.

A new location and new operating policy are credited for the ability of White Rock District Hospital Auxiliary to donate another $1,000 to the reserve fund for equipment at White Rock District Hospital. The money was raised in the summer by such successful projects as the Superfluity Shop.

Auxiliary Purchases Cardiograph

The Union Hospital Auxiliary of Wakaw, Saskatchewan, has donated an $800 electrocardiograph machine to assist in the diagnosis of heart conditions at the hospital. The mechanics of the machine were explained to the auxiliary at their meeting.

Yule Fuel

IT is good to provide a festive atmosphere for patients and employees who must be away from their homes during the holiday, but hospitals have a profound obligation to use every safeguard against fire.

Some hospitals, although they sacrifice a little Christmas atmosphere for the sake of safety, store and reuse flameproof, artificial trees. The initial expense of permanent decorations is made up over the years in accidents avoided. For those who prefer traditional trees, fire protection engineers recommend some common sense rules.

Fresh trees should be cut off at an angle, one inch above the original cut in the base. Stand the tree in a pail of water, adding coal or sand for support. If the pail is refilled as the water evaporates it will take longer for the tree to dry out, and the flammability is reduced as effectively as by using any fireproofing chemical.

Never use candles on or near the tree. Standard electrical lighting sets should bear the label of Underwriters' Laboratories or the Canadian Standards Association. Check the condition of sockets and wires, and discard sets with frayed wiring. Actually, the safest and most effective lighting is a coloured spotlight on the tree.

See that your circuits are not overloaded. If a fuse blows, eliminate some of the appliances on the circuit. Change the position of a light if nearby needles are turning brown in order to keep the lights away from combustible material. Be sure that the switch, a safe distance from the tree, says "off" before you leave.

Cotton, paper, and pyroxylin ignite easily, and burn intensely. A tree decorated lightly with noncombustible metal, glass, or asbestos, is much less dangerous. Celluloid dolls, and toys powered by alcohol, kerosene or gasolene are threats to a happy holiday. Power toys should be operated only under adult supervision; film projectors should use safety film; electrical toys should also bear a U.L. or C.S.A. label. Setting up an electric train under a Christmas tree is not sensible.

A blazing hearth is a Christmas welcome, but see that you have a substantial screen over the entire opening. Your tree should be no closer to it than 10 feet. Instead of stuffing wrappings in the fireplace gather the waste immediately and dispose of it outside.

Hospitals at Christmas are decorated and crowded with visitors. The added hazard of decorations should be countered with enforced NO SMOKING signs. Decorations must not be allowed to block or hide exits. So that the high spirits of the holidays do not become panic and fear, hospitals must prepare themselves for the season's dangers. Fire extinguisher ready? Merry Christmas.

Provincial Notes—
(continued from page 73)

Crows Nest Pass Hospital was presented with a respirator by Blairmore Legion of Coleman, Alta. The Alberta Chapter of the Canadian Foundation for Poliomyelitis is sponsored by the Canadian Legion, Alberta Command.

High River Municipal Hospital has agreed to purchase one of the electrocardiograph machines which have been on trial at the hospital for the past two months.

Strict compliance with existing regulations in regard to times of admissions and discharges at the Taber Municipal Hospital is to be maintained. While exception is made for emergencies and mat-

ernity cases, this more careful regulation will avoid confusion.

British Columbia

The new Burns Lake Hospital, designed by Whittaker and Wagg of Victoria, is to be the main project of the Centennial Committee for 1958, B.C.'s centennial year. The committee has decided to donate $6,000 toward a new x-ray machine.

When he gave official approval to construction of a 52-bed addition to Royal Inland Hospital, Health Minister Eric Martin recommended that a wing be built at the same time for long-stay patients. The additional 52 beds will bring the total number to 230 beds available at the hospital, to acute patients.

The Salvation Army is planning construction in Vancouver at an estimated cost of $1,500,000. Its contribution to the B.C. centennial will include modernization of Grace Hospital, and a 30-bed annex. Architects for the extension are Mercer and Mercer.

Kimberley Hospital, a 42-bed, two-storey frame building with faulty wiring, is to be replaced by a new 57-bed structure capable of 50 per cent expansion. The site chosen is adjacent to old building.

Fruit growers and freight lines have co-operated for several years to send gifts of fruit to the Health Centre for Children of the Vancouver General Hospital, and the Children's Hospital operated by the Children's Hospital Society. Children from all over the province have enjoyed fruit in season and apples on Hallowe'en.

Splitting Hairs

I see that a scientist has said that an excellent relaxation from work is to count the hairs on a fly's leg.

I imagine that very tired people would merely guess at the number, or even cheat, and announce a figure at random, leaving the checking to a more painstaking companion.

The game can be made more exciting by using a fly that has been walking about in marmalade. Several hairs get stuck together, and the separation of them is a task for only the most conscientious people. In Papua the pigmies use these hairs to make strings for their tiny violins. The music is almost inaudible, and as the hairs snap very easily, few Papuans are willing to pay for violin lessons for their children.—*English Digest.*

Hamilton General Hospital, in his paper on "The Effect of Proposed Insurance on Hospital Pharmacy", outlined its effect on pharmacy in Great Britain, other countries, and in the provinces of British Columbia and Saskatchewan which now have this type of insurance.

A panel discussion on "The Value of Retail Pharmacy Service to the Smaller Hospital" was chaired by John Zugich, University Hospital, Ann Arbor, Mich. W. R. Foltas of Oakville-Trafalgar Memorial Hospital, presented the viewpoint of the hospital pharmacist; R. W. Knaggs, Long Branch, spoke as a retail pharmacist; and Robert Ferguson, as the administrator of Humber Memorial Hospital, Toronto, stated his viewpoint.

Consideration was given to the various ways of utilizing the services of a hospital pharmacist in a small hospital which wishes to employ a pharmacist but feels that the amount of work in the pharmacy alone does not warrant the need of a full-time hospital pharmacist. However, the consensus of opinion was that if a hospital is not able to employ a pharmacist on either a full-time or part-time basis, retail pharmacy service is of real value not only in providing the drugs needed, but also as a means of providing consultation on pharmacy problems.

The guest speaker for the luncheon, Mrs. Charles McLean, Honorary vice-president of the Ontario Hospital Association, was introduced by Miss Takenaka. In her address, "Rx for Service", Mrs. McLean outlined a short history of the Ontario Hospital Association, spoke of its functions, and pointed out to the members of the Ontario Branch of the Canadian Society of Hospital Pharmacists the many ways in which they can be of service to hospitals of Ontario.

The afternoon session started with a panel discussion on the controversial subject, "Should the Ontario Pharmacy Act Cover Hospital Pharmacies?" John Zugich acted as chairman and co-ordinator of this panel, while representatives of the various hospital and health groups presented their viewpoints. Mrs. Stauffer, special lecturer on hospital pharmacy, Faculty of Pharmacy, University of Toronto, told of the work done to date on this matter by the Ontario Branch of the Canadian Society of Hospital Pharmacists. Ellen McLean, director of nursing, Northwestern General Hospital, Toronto, pointed out that nurses are not trained to give pharmacy service in hospitals but are called upon to do so in many instances. Dr. David MacKenzie, Toronto, representing the Ontario Medical Association, stressed the real need for a pharmacist in a hospital who can be a consultant on drugs with members of the medical staff. E. R. Willcocks, superintendent, Toronto East General and Orthopaedic Hospital, felt that it is wrong for hospitals to take advantage of the situation, since hospitals are not required by law to employ a pharmacist for pharmacy service. This is a problem which will require a great deal of careful consideration in the light of the present-day shortage of hospital pharmacists, he said. This panel discussion revealed that other hospital and health groups are not aware of the pharmacists' situation. Panel members felt that the problem should not be taken lightly as numerous factors present great difficulties.

Two papers on ophthalmic solu-

tions were given by Beth Wingfield, pharmacist with the Queensway General Hospital, and Isobel Shelton, pharmacist with Toronto Western Hospital. Mrs. Wingfield outlined the actual procedure of the preparation of the various eye solutions; and she evaluated the effectiveness of various preservatives used in these solutions by clinical trials in doctors' offices and hospital clinics.

In her paper, "Buffers in Ophthalmic Solutions", Mrs. Shelton, dealt with pharmacological activity of the active ingredients at different pH in various buffer solutions. She stressed the need of buffers in ophthalmic solutions both for stability and activity of the eye solution and for the patient's comfort.

The president called upon Catherine Haffey to present a report of the Resolutions Committee. Isobel Shelton gave the report of the Nominating Committee.

The new officers for 1958 are: *president*, I. Griffith, chief pharmacist, Queensway General Hospital, Toronto; *vice-president*, Love Chabak, pharmacist, Women's College Hospital, Toronto; *secretary*, Sarah Bucci, pharmacist, St. Joseph's Hospital, Hamilton; *treasurer*, Robert Kipp, pharmacist, Kitchener-Waterloo Hospital, Kitchener.

—*Irene Kostuk.*

B.C. Hospital Pharmacy Fellowships

A one-year hospital pharmacy internship program has been made available to pharmacy graduates of the University of British Columbia for the first time this year. The new hospital pharmacy internship, designed to help fill the shortage of qualified hospital pharmacists is being sponsored jointly by the U.B.C. Faculty of Pharmacy, the Vancouver General Hospital, and the Royal Jubilee Hospital, Victoria. The program, extending over a 12-month period, will include 2,000 hours of training in hospital pharmacy administration, dispensing, and manufacturing.

In conjunction with the program, two $500 fellowships were awarded to pharmacy graduates taking hospital internship. The Pfizer fellowship in hospital pharmacy was awarded to Ellen A. Arnet, B.S.P., of Port Alberni, B.C., and the H. C. LePatourel fellowship was given to John P. Berdusco, B.S.P., of Prince George, B.C. Miss Arnet is serving her internship at the Royal Jubilee Hospital, while Mr. Berdusco is studying at Vancouver General Hospital.—*Hospital Pharmacist.*

Ontario Conference of Catholic Hospitals

"While you implement the new techniques and skills so vital, keep before you the old technique of charity," urged Most Rev. F. V. Allen, as he introduced the spiritual theme of the 24th annual meeting of the Ontario Conference of the Catholic Hospital Association held in Toronto, Oct. 31st to Nov. 1st.

Sister Mary Kathleen, president of the Ontario conference, welcomed Rev. J. J. Flanagan, S.J., executive director of the Catholic Hospital Association of the U.S.A. and Canada, Murray W. Ross, representing the Canadian Hospital Association, and H. M. Jackson of the Ontario Hospital Association. Each brought greetings from his organization. Sister Mary Kathleen congratulated Msgr. J. G. Fullerton on his recently being made an honorary fellow of the American College of Hospital Administrators, and especially applauded the efforts of several Orders. Sister Janet, Superior of St. Michael's Hospital, Toronto, welcomed the members to the conference, held at that hospital.

"The Ontario Hospital Services Plan," said Msgr. Fullerton in his address on that subject, "is confined to standard ward care; but by reason of its other broad features it will cover by far the major part of the non-medical bills of those who require hospitalization." Benefits will be available to everyone, he assured the assembled nuns, who is paying premiums, and to persons in receipt of social assistance payments on a means test basis without limitations. Private groups such as Blue Cross will concentrate on supplementary benefits, he continued, while basic ward coverage will be carried only by the Ontario Hospital Service Commission.

W. I. Christopher of St. Louis. Mo., spoke on "Evaluating our supervisors for a stronger management team". Dr. Charles Bardawill. who is now doing research at St. Michael's Hospital, Toronto, discussed antibiotics. The rehabilitation program at Lyndhurst Lodge. Toronto, was described by its director, Dr. A. T. Jousse, who is also consultant for the department of physical medicine at Sunnybrook Hospital.

The final day of the conference was devoted to accreditation of schools of nursing, discussed by Sister Francoise de Chantal, Sudbury, and Sister Mary Ruth, Parkersburg, West Virginia; and to evaluation of spiritual objectives, on which addresses were given by Rev. J. J. Flanagan, Rev. Matthew G. Meehan, Brockville, and Rev. G. B. Flahiff, Toronto.

The new executive installed included: *president*, Sr. St. Elizabeth, St. Joseph's Hospital, London; *1st vice-president*, Sr. Francoise de Chantal, St. Joseph's Hospital, Sudbury; *2nd vice-president*, Sr. Evangeline, Pembroke General Hospital, Pembroke; *3rd vice-president*, Sr. Estelle, St. Joseph's Hospital, Toronto. The executive board is completed by Sr. Mary Kathleen, St. Michael's Hospital, Toronto; Sr. Madeleine of Jesus, Ottawa General Hospital, Ottawa; Sr. Frances de Sales, and Sr. Janet of St. Michael's Hospital, Toronto; Sr. Joan of St. Joseph's Hospital, North Bay; and as secretary, Sr. Murphy of Hotel-Dieu Hospital, Cornwall.

Illuminated Telephone

A telephone made entirely of translucent material, which lights up whenever a call is received has been designed in England to work in conjunction with a range of private internal telephone systems. The light emitted through the case is sufficient to locate the phone quickly and jot down any notes without switching on the main lights. When a call is rung a neon lamp flashes until the handset is lifted and then a 12-volt lamp lights. This telephone is intended chiefly for hospital doctors and others who frequently have to take calls at night.—*The Hospital.*

Coming Conventions

Feb. 7-8—Midyear Conference of the American Hospital Association, Palmer House, Chicago, Ill.

Feb. 9-11—25th Anniversary Commemoration and Congress on Administration of the American College of Hospital Administrators, Congress Hotel, Chicago, Ill.

Mar. 3-6—Joint Nurses-Surgeons meeting sponsored by the American College of Surgeons, Commodore Hotel, New York City.

June 12-14—Canadian Association of Physical Medicine and Rehabilitation, Annual Meeting, Quebec City, P.Q.

June 16-20—Canadian Medical Association Convention, Nova Scotian Hotel, Halifax, N.S.

June 21-22—Conference of Catholic Schools of Nursing, annual meeting, Atlantic City, N.J.

June 21-26—Catholic Hospital Association of the United States and Canada, annual convention, Atlantic City, N.J.

June 23-27—Canadian Nurses' Association 50th Anniversary Meeting, Lansdowne Park, Ottawa, Ontario.

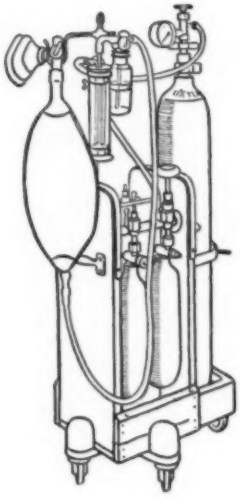
June 25-27—Comité des Hôpitaux du Québec, annual convention and Commercial and Scientific Exhibition, Montreal Show Mart, Montreal, P.Q.

1917

THE ORIGINAL

BOYLE APPARATUS

A sturdy wooden case containing cylinders of nitrous oxide and oxygen . . . and a simple control for gases, marked the introduction of the first practical anaesthetic apparatus. Designed by Dr. Boyle for Britain's War Office and used in the field in 1917, B.O.C. manufactured the first model and have since proved and improved the Boyle principle.



Many Anaesthetists now favour the Boyle design over any other type, but in particular it is the B.O.C. Boyle, with its proven service and quality of workmanship that is in demand across Canada. Write for information on the B.O.C. Boyle.

OVER 40 YEARS OF SERVICE TO ANAESTHESIA

1958

LATEST BOC BOYLE

Today the B.O.C. Boyle has been accepted as the finest anaesthetic apparatus of its kind in the world. The Model "H" illustrated above is one of 5 models now being installed in hospitals across Canada.

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Making-do

(concluded from page 36)

quire careful exploration in order to preserve the strengths of professional associations and eliminate the weaknesses of isolated approaches to the same problems.

Summary

Three facets of the Art of Making-do have been presented. Each portrays the needs of the individual who requires the services of restorative medicine. First, a broader, possibly newer, view is desirable in this field. There are three sides to restoration of the individual, mobility, body functions and spirit, not the least of which is spirit. The restored individual must be afforded an opportunity to "live-it-up", even if he must remain in bed. Secondly, "boring-from-within" is essential if we are to avoid insularity of our institutions which must work together if our patients are to profit as much as they should from the commodity of co-operation. The task is best begun at home. Without co-operation, people, money and facilities are almost meaningless. Thirdly, there is need to economize in the human resources required in restorative medicine. If the patient is to profit from restoration, a team must be created in which each individual has his task which he performs with pride in the knowledge that only by working together can the plus-values of restoration be won for the patient. Successful restoration is dependent upon making-do with the assets of the individual, the institution and the professions.

You Were Asking

(concluded from page 56)

person. Once they have been signed they are summarized on a comparison sheet and presented at a regular board meeting for their consideration and award of the contract.—*Gordon Frith, Administrator.*

* * *

Strathroy General Hospital, Strathroy, Ont.

WE do not purchase commodities such as fuel, bread, or milk, by tender, because we are in such a small town. Fuel and milk are bought on a six months successive contract from the two competing firms here. Bread comes from one local company on a yearly basis.

To prove we are not paying an excessive amount, we ask for competitive prices from the other companies delivering in town; we find that our present price is still the lowest.

Our insurance is handled by a local insurance broker, and subsequently the premiums are divided among the remaining insurance men in town.

Meat is bought from the wholesalers, and delivered at the door.

We advertise for tenders only for maintenance. The tenders are opened and decided upon at a meeting of the property committee. Then a recommendation is given at a board meeting.—*Dorothy Doan, Superintendent.*

Peace

Peace is never long preserved by weight of metal or by an armament race. Peace can be made tranquil and secure only by understanding and agreement fortified by sanctions. We must embrace international co-operation or international disintegration. — *Bernard Baruch.*

INCERT

new... unique one-step additive vial saves time, labor and money in your hospital

NO AMPULES... NO NEEDLES ...NO SYRINGES

Simply remove tamperproof cover of INCERT and push sterile plug-in through large hole in stopper of solution bottle. It's that easy... and a completely closed, sterile system.

EXCLUSIVE HOSPITAL-USE FEATURES

CONSERVES TIME — Instantaneous automatic supplementation of bulk parenteral solutions.

COMPLETELY STERILE—Closed system, from preparation to administration.

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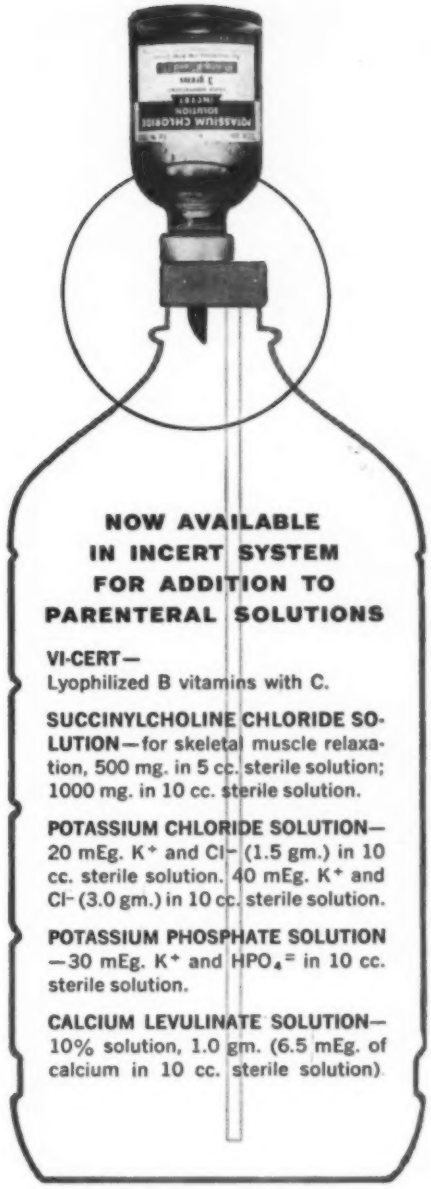
SIMPLE TO USE—A foolproof system that eases the hospital care load.

***INCERT SYSTEM** is an original development of Travenol Laboratories, Inc. Complete literature and samples on request.*



NOW AVAILABLE IN INCERT SYSTEM FOR ADDITION TO PARENTERAL SOLUTIONS

VI-CERT—
Lyophilized B vitamins with C.

SUCCINYLCHOLINE CHLORIDE SOLUTION—for skeletal muscle relaxation, 500 mg. in 5 cc. sterile solution; 1000 mg. in 10 cc. sterile solution.

POTASSIUM CHLORIDE SOLUTION—20 mEg. K^+ and Cl^- (1.5 gm.) in 10 cc. sterile solution. 40 mEg. K^+ and Cl^- (3.0 gm.) in 10 cc. sterile solution.

POTASSIUM PHOSPHATE SOLUTION—30 mEg. K^+ and $HPO_4^=$ in 10 cc. sterile solution.

CALCIUM LEVULINATE SOLUTION—10% solution, 1.0 gm. (6.5 mEg. of calcium in 10 cc. sterile solution)

TRAVENOL LABORATORIES, INC. MORTON GROVE, ILLINOIS

Pharmaceutical Products Division of **BAXTER LABORATORIES, INC.**

News Released by Hospital Supply Houses

By C.A.E.

New District for Abbott in Quebec

The management of Abbot Laboratories Limited has just announced the setting up of a new district, with head office in Quebec, to be headed by Guy Labelle of Quebec

G. Labelle

City. This new district will include the towns of Three Rivers and Sherbrooke, the Lake St.-John area, the Southern Shore and Gaspe Valley as well as the Maritimes and Newfoundland.

Canadian on Directorate of Procter & Gamble

The 120-year-old Procter & Gamble Company of Cincinnati has gone outside of the United States for the first time to name a Canadian to its board of directors.

Elected is one of Canada's leading department store and mail order executives, Edgar Gordon Burton, C.B.E., 53-year-old chairman and president of the Robert Simpson Company.

W. E. Williams, president of the Procter & Gamble Company of Canada, Limited, P & G's oldest subsidiary outside the U.S., commented: "The naming of Mr. Burton to the board of our parent company not only recognizes the strength he will add to the organization, but also is a tribute to the warm relationship P & G has enjoyed with Canadians for more than 40 years".

The P & G of Canada factory at Hamilton, Ontario, has been in operation since 1915. At that time it was the first P & G plant outside of the U.S. Today the parent company has 82 manufacturing facilities around the world.

"Further proof of the company's interest in Canada," Mr. Williams added, "is the construction of a new multi-million dollar shortening plant in the Montreal area".

Two New Addressograph Machines

A giant step toward practical paperwork automation for small and large institutions was taken recently with the release for sale of two new, portable low-cost machines by the Addressograph-Multigraph Co. of Canada Limited, Toronto 13.

One, the Graphotype Class 350, is a portable Addressograph plate-embossing machine created especially for small volume requirements. The other, the Addressograph Class 200, is designed for fast, error-free repetitive writing in clerical operations of every description.

The embossing machine provides small businesses and the individual departments of large organizations with a convenient, inexpensive means of maintaining their own Addressograph plate files. Whether the need is for conventional, repetitive data plates, short message-writing plates, identification tags or plastic record cards, this new machine enables the Addressograph user to put additions and changes into file as soon as they occur. The machine is not much larger than a standard office typewriter. It is simple to operate for even the newest employee.

The Addressograph Class 200 makes it possible for small businesses and organizations to mechanize the writing of all types of repetitive data, and in larger offices to extend Addressograph benefits to every department.

Norelco Publishes Book on Microradiography

A new 48-page Norelco book entitled "Principles of Microradiography", which includes a bibliography prepared by Eastman Kodak Research Laboratories on the subject of Microradiography and Soft X-ray Radiography, is available free from the Instruments Division, Philips Electronics, Inc., 750 South Fulton Avenue, Mount Vernon, New York.

The volume was prepared for the special symposium on microradiography which was part of the program at the conference of the Electron Microscope Society of America held at the Massachusetts Institute of Technology in September 1957.

One section is devoted to the principles of microradiography and discusses contact and projection

(continued on page 92)

Here's a new blanket...

to end shrinkage problems

woven by KENWOOD

from a patented process* made possible with

Orlon

This new addition to the excellent line of renowned KENWOOD blankets is the answer to shrinkage and "matting" problems resulting from adverse and abusive laundry conditions. The blend of 75% wool 25% "Orlon" acrylic fibre woven from the patented process combines the best qualities of both fibres.

- **Virtually no shrinkage... means longer life**
- **Retains original color and good appearance**
- **Provides warmth with less weight**

**The manufacture of this blanket is based on a U.S. and Canadian patent covering the use of acrylic fibre to reduce shrinkage in a predominantly wool blanket. The results of 50 test launderings of this particular blanket showed shrinkage of less than 2%.*

The new KENWOOD blankets come in attractive colors that harmonize with any color scheme.
Available through
KENWOOD MILLS LIMITED
Arnprior, Ontario.

DU PONT CANADA

DU PONT COMPANY OF CANADA (1956) LIMITED • MONTREAL

Across The Desk

(continued from page 90)

techniques together with x-ray microscopy. Other subjects covered include definition, geometrical blurring, film unsharpness, unsharpness due to movement, contrast, soft x-rays, increasing contrast in the specimen, increasing contrast with photographic material, and photomicrographs. The text also treats such topics as specimen preparation techniques and applications. Similarly handled are medical-biological applications such as examinations of bone and tissue.

Nearly 500 references are listed in the bibliography which covers articles on conventional microradiography and soft x-ray radiography, geometric x-ray microscopy, x-ray microscopy, and electron radiography.

Down Bros. Representative Moves to Alberta

M. G. Magnee, representative for the well-known medical supply firm of Down Bros., Toronto, is to take up permanent residence in Alberta. His duties will be to act as sales representative for the province.

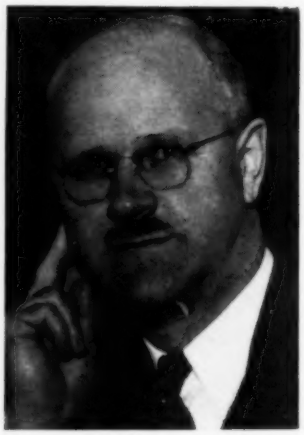
M. G. Magnee

Mr. Magnee was a member of the staff of the parent organization in London, England, before joining Down Bros. in Canada just over 18 months ago. He has wide experience in the field of surgical instruments and medical supplies, experience which will now be available to serve the hospitals and medical centres of Alberta.

The company has been making instruments and supplies for hospitals all over the world since 1870.

L. B. McNICHOL

Lawrence B. McNichol, vice-president and general manager of The Stevens Companies, died suddenly on Friday, November 15. Mr. McNichol was manager of the Winnipeg office of the wholesale hospital and surgical supplies firm until his appointment as vice-president and general manager in Toronto in 1937. He was a member and deacon of High Park Baptist church and a member of the Granite Club.



One of Mr. McNichol's principal hobbies was curling, and he died on the ice while following his favourite pastime. He was well and favourably known to a host of hospital executives and physicians throughout the country, who will deeply regret the passing of a fine gentleman, and a highly respected businessman.

J. J. S. HOLMES

J. J. S. (Jim) Holmes, 46-year-old vice-president in charge of sales of the Kellogg Company of Canada, died suddenly at London on Friday, October 4.

The late Mr. Holmes joined Kellogg's at Toronto in 1941, was moved to the Maritimes in 1942, and in 1944 returned to Toronto in charge of detail salesmen. In 1948 he was transferred to company headquarters at London as Canadian sales supervisor, and a year later was named sales manager. His appointment as vice-president and director came in 1950.

New Waterproof Sheeting With Silicones

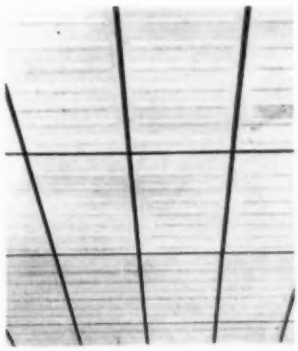
A new improved hospital sheeting material has been developed by Duplan of Canada Limited, Valleyfield, Quebec. Combining the use of "Terylene" polyester fibre and "Union Carbide" silicone rubber compounds, it has been developed as an improved sheeting material for use in hospitals and institutions. Featuring excellent chemical and heat resistant qualities, it also proves to be more comfortable and has longer wear.

This new silicone rubber sheeting has been Canadian hospital tested, and, it is claimed, has beneficial properties which offset the more expensive new materials utilized to perfect this item.

Greater durability can be expected from this type of sheeting due to its high initial strength and to its resistance to chemicals. Acids, alkalies, detergents, soaps, bleaches and uric acid have little effect on this inert material. This sheeting also has high seam strength. Samples of this material have been steam autoclaved for sterilization and there was no deleterious effects after 50 treatments at 250° F. This material can be easily cleaned with normal detergents or soaps, and will not retain offending odours. Comfort is an added and important feature, as this sheeting is soft and flexible and does not produce the clammy feel of the normal waterproof sheeting.

Celotex Introduces Translucent Ceiling Panels

The Celotex Corporation has introduced two additions to its line of Acousti-Lux light-diffusing panels for translucent ceilings.



Used in conjunction with a suspended ceiling system and a fluorescent light source, the new panels help provide comfortable, glare-free lighting, an important factor in hospital installations.

The new Septaline and Southland designs are available in 24 by 24-inch and 24 by 48-inch sizes. Acousti-Lux panels consist of

(concluded on page 94)

Position Vacant at

The Montreal Children's Hospital

ASSISTANT EXECUTIVE DIRECTOR

Must be a medical graduate and preferably a graduate of a Hospital Administration course.

Please apply to

Dr. J. E. de Belle, Executive Director,

The Montreal Children's Hospital

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Prudham Building Specialties Ltd., 7939 - 104th Street, Edmonton, Alta.
Wall Covering Centre of Ontario, 664 Vaughan Rd., Toronto, Ont.

Across The Desk

(concluded from page 92)

two sections of moulded vinyl separated by an air space of one-half to two-and-a-half inches, providing sound absorption and uniform translucense across the ceiling surface.

Installation of the units is made either in combination with sound-conditioning tile or in an over-all translucent ceiling design, depending upon the lighting, acoustical, and decorative requirements of the area. The company has pointed out that the new panels, like others in the broad Acousti-Lux line, are engineered to meet specific job and design requirements.

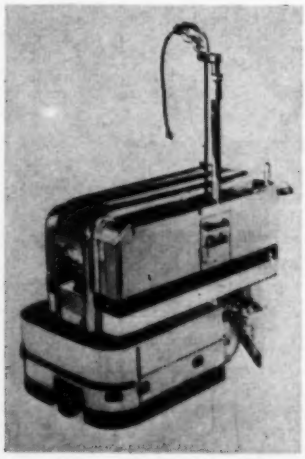
The Septaline panel is designed so that its exposed surface extends below the level of the suspension grid system. The panels thereby tend to conceal the suspension system, and since light is cast from the panels onto the grid, the suspension system appears white, like the panels themselves. The result is an over-all white appearance with minimum visual emphasis on the grid pattern.

The Southland unit is installed flush on top of the suspension system. Since the panels do not project below the grid, the ceiling is in a single horizontal plane. This panel, therefore, can especially be applied to areas with ceiling-high movable partitions, since the partitions can be moved anywhere beneath the completely level ceiling.

Accousti-Lux ceilings are installed by franchised distributors of Celotex Acoustical Products.

Cleans 24,000 Square Feet per Hour

Wood's new ClarkeAmatic streamlined floor maintainer will scrub, rinse and dry 24,000 square feet of floor space in one hour. This new floor machine is self propelled at the required speeds; floor cleansing solutions are automatically metered to the twin scrubbing brushes, then all in the same operation the dirt and used scrubbing solution is picked up and the floor vacuum dried.



If you have a large floor area cleaning problem, enquire about the streamlined Wood's Clarke-Amatic Floor Maintainer. Contact G. H. Wood & Company at Toronto, or any of their branches.

Dominion Oilcloth & Linoleum Sales Appointments

K. B. Roberton, president of Dominion Oilcloth & Linoleum Company Limited, has announced that A. C. Carlaw, sales manager

A. C. Carlaw

since 1946, has been named to the new position of general sales manager. Mr. Carlaw joined the firm in 1931 as a salesman covering British Columbia, and later was moved to the Montreal head office. In 1943 he was named assistant to the sales manager, and three years later sales manager.

At the same time other appointments in the sales department were announced as follows: C. F. Coristine is sales manager and P. L. Chamberland, assistant sales manager. R. Bricault assumes the new position of manager of contract sales.

Linde Unit Chills at Minus 320° F. Without Power Supply

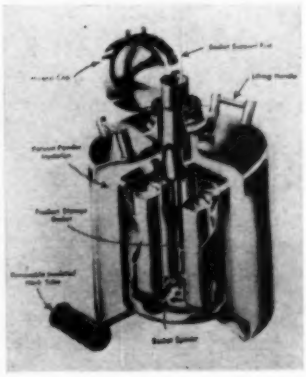
The rapidly expanding field of cryogenics (the science of cold) now has a remarkable new tool. Linde Air Products Company, Division of Union Carbide Canada Limited, has announced a portable liquid nitrogen refrigerator for laboratory and practical use in science and industry.

Linde believes that the new refrigerator, designated the LNR-25B, will find immediate use in such fields as medical and pharmaceutical research; and many uses in industry.

The new container was not offered until it went through years of development testing and until it was successfully field-tested for more than two years. It was found to be economical, durable and practical, and hence is now made available to science and industry.

Here's how the new unit works: A double-walled (contained within a container) jacket of Heliarc welded stainless steel is insulated by a Linde-developed vacuum-powder combination. The inner container is filled with liquid nitrogen having a temperature of 320° F. Accessory storage baskets filled with material for freezing or cold storage are lowered into the liquid nitrogen.

Possible immediate applications of Linde's new portable liquid nitrogen refrigerator in medical and hospital fields are of indefinite preservation of enzymes, hormones and proteins; storage of whole human blood, arteries, bones and tissues; storing of bacterial cultures without transplanting and preservation of cancer cells at various stages for study.



Boss: "You're late this morning, Sam."

Sam: "Yes, when I looked in the mirror this morning, I couldn't see myself, so I thought I'd gone to work. Then later I discovered the glass had dropped out of the frame."

GENERAL INDEX

The Canadian Hospital

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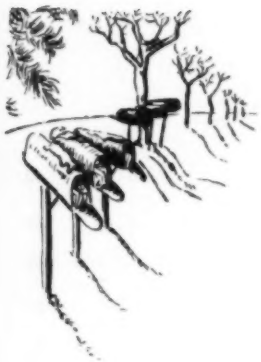

THE CANADIAN HOSPITAL

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